CalvertHealth™
Medical Group

Bariatric Surgery
New Patient Information

Welcome to the Metabolic and Bariatric Surgery program at CalvertHealth Medical Center

You are about to embark on a new life altering experience that will help you improve your overall health and well-being! The Metabolic and Bariatric Surgery program at CalvertHealth Medical Center is a multidisciplinary program launched in May 2021 that aims to offer the most comprehensive, thorough, and up to date treatments to treat obesity and its medical implications.

The word *"bariatric"* is a term that comes from two Greek words that mean "weight" and "treatment". Therefore, "bariatric surgery" can be defined as treating weight by surgery. The term *"metabolic"* was recently added to "bariatric surgery" because of the known and proven improvements seen in the metabolic profiles of patients undergoing bariatric surgery. You and your Primary Care Physician have decided bariatric surgery may be an option for you. The decision to recommend surgery for the treatment of obesity requires multidisciplinary input to evaluate the indications for operation and to define and manage co-morbidities properly. The Metabolic and Bariatric Surgery Program team will help you make the final decision as to whether surgery is the *best* option for you.

This path you have chosen is going to help alleviate a lot of your health issues and concerns, at the heart of which is obesity. Years of experience have shown us that, when it comes to bariatric surgery, the most successful patients are the most informed. As such, as you go through our program, the team of experts will stress the need to stay well informed and ensure that you have an excellent understanding of the steps and expectations you should encounter.

Again, by being here and reading this, you are considering what is likely going to be the best decision you have taken in terms of improving your health and life in general. On behalf of the entire multidisciplinary team here at CalvertHealth Medical, I would like to congratulate you on making this brave decision and look forward to helping you achieve your goals.

Ramzi Alami, MD FACS FASMBS

Medical Director of the Metabolic & Bariatric Surgery Unit

CalvertHealth Medical Center

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I am interested in: Gastric Bypass Gastric Band Revision/ removal Sleeve Gastrectomy

How did you hear about our program? _____

Contact Information

Patient: _____
Patient Address: _____
_____
_____

Patient Telephone: (_____)_____
Patient Email: _____
Date of Birth: _____

Referring MD: _____
MD Address: _____
_____
_____

MD Telephone: (_____)_____
MD Email: _____

Primary MD: _____
MD Address: _____
_____
_____

MD Telephone: (_____)_____
MD Email: _____

Psychologist: _____
Address: _____
_____
_____

Telephone: (_____)_____

Preferred Pharmacy: _____ **Ph:** _____

Insurance Carrier: _____ **State:** _____

Have you called to verify that Bariatric Surgery is a covered benefit? Please confirm this for the Gastric Sleeve (CPT 43775) and Gastric Bypass (CPT 43644) surgeries.

_____

Does your insurance require a supervised diet? (*be sure to ask*) _____

Your Current Height: _____
Your Current Weight: _____

BMI: _____

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Bariatric History:

How long have you been looking into having weight loss surgery? _____
Have you ever been evaluated for weight loss surgery before? Yes/ No _____
Have you ever had weight loss surgery, and are interested in a revision? _____
When did weight become a problem for you? Child Teen Adult With Pregnancy
At what age did you first begin dieting: _____ years old
Are your family members heavy? Yes/ No which ones? _____
What do you feel has caused you to be heavy? Major Illness Major Stressor
Medication Marriage Travel Trauma Divorce
Food Choices Inactivity Genetics Other_____
What was your highest adult weight? _____ Lbs. When? _____
What was your lowest adult weight? _____ Lbs. When? _____

Eating Patterns:

Describe your eating habits: _____
Do you skip meals? Yes/ No If so, which? _____
What do you drink? _____
How often do you drink sugar sweetened beverages? _____
Do you have any difficulty swallowing? _____
Are you allergic or intolerant to any foods? Yes/ No If so, which? _____
Do you eat big meals, or have difficulty feeling full? Yes/ No If so, which? _____
How often do you eat outside the home/ include fast food? _____x's a week

Exercise or Activity:

Describe your exercise habits: _____
How often do you exercise? I don't Daily 2x/week 3x/week 4x/week
What are your barriers to exercise? _____
Can you walk up a flight of stairs without stopping? Yes/ No
Do you get chest pain or shortness of breath on exertion? _____
How far can you walk without stopping? <10 mins 15 mins 30 mins >30mins

Psychological Eating/ Problems:

Do you have any mental health concerns? _____
Have you ever been hospitalized for mental health illness? _____
Are you experiencing any major life stressors currently? _____
Do you ever have binges (eating a large amount of food in a short period of time)? _____
Are you under the care of a psychologist/ psychiatrist/ counsellor? _____
Do you take any medications for mental health reasons? _____
If yes, who prescribes them for you? _____

Sleep:

Describe your sleep habits: _____
Do you have any difficulty sleeping? _____
Have you ever been tested for sleep apnea? _____Do you wear a CPAP?
Do you take sleep aides? _____

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Weight Loss Attempts

Program	Describe/ Year	Months on Program	Pounds Lost	Comments	Cost ($)
Diet pills (any)					
Weight Watchers					
Liquid Diets (Optifast or Slim Fast, etc.)					
Low calorie diets					
Low carb diets or Atkins					
Jenny Craig or Nutri-System					
Fad diets					
Physician Monitored Diet "Diet Clinics"					
Hypnosis/ counseling					
Surgery					
Dietician Counseling					
OA					
Gym Memberships Exercise Plans					

What diet/ weight loss plan has worked the best?

What do you feel has been your biggest barrier to losing weight?

Why do you want to have weight loss surgery now?

What surgery are you most interested in having and why?

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Personal Health History:

Medical Problems (Circle all that apply)

Diabetes	High Blood Pressure	Sleep apnea	Cancer
Heart Disease	Reflux/ Heartburn	High Cholesterol	Stroke
Stress Incontinence	Gallstones	Arthritis	COPD
Chronic Pain	Low Back Pain	Changes in Period/ PCOS	
Glaucoma	Blood Clots	Kidney or Liver Disease	
Venous Stasis	Heart Attack	CHF	
Asthma	Depression	Bipolar Disorder	

Any other Medical History/ Hospitalizations:

_____

_____

_____

_____

Surgical History (YEAR):

Tonsillectomy _____ Gallbladder Removal _____ Appendectomy _____

C- Sections _____ Hernia Repair _____

Any other operations:

_____

_____

Allergies:

_____

_____

Current Medications:

Medication	Amount (mg)	Frequency	Since (year)

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Social History:

Where are you from? _____

Where do you live now? _____

Education: _____

Describe your living arrangements? _____

Marital Status:

□ Single □ Married □ Divorced □ Widowed □ Other

Children: _____

Any desire for children in the future? Yes/ No

Current Occupation: _____ **Employer:** _____

Years at this position: _____ **Can you take time off to recover?** _____

Are you on disability? _____ **If so, since when and for what reason?**

_____

Who will help take care of you, if needed, after surgery? _____

Habits:

Do you take any vitamins, herbs, supplements?

_____

_____

Do you (or did you) smoke? □ Yes □ No □ Quit _____ years ago

You must be nicotine free x 3 months before surgery

Average daily tobacco habit: _____ packs/day for _____years

Do you drink alcoholic beverages? □ Yes □ No □ Quit _____ years ago

How much? _____

Do you use recreational drugs? □ Yes □ No □ Quit _____ years ago

You must be drug and alcohol free x 6 weeks before surgery

Do you have, or have you had, a problem with drugs or alcohol? □ Yes □ No

Explain: _____

Family History:

Biological Father (alive or deceased) Age: _____ Medical Hx: _____

Biological Mother (alive or deceased) Age: _____ Medical Hx: _____

Extended Family (Siblings, Grandparents, your children): (list anything of importance)

_____

_____

_____

_____

_____

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Are you experiencing (currently):

Recent unexplained weight loss or weight gain		Fevers/ Chills	Night Sweats
Dizziness	Headaches	Weakness	Fatigue
Coughing	Wheezing	Shortness of Breath	Chest Pain
Pressure in Chest	Palpitations	Heartburn	Snoring (apnea)
Daytime Drowsiness	Insomnia	Trouble swallowing	Constipation
Change in Bowels/ Bloody Stools		Abdominal Pain	Hernias
Pain or difficulty Urinating		Libido changes	Skin changes

Health Maintenance:

Do you see a healthcare provider regularly?

Do you see a dentist regularly?

When was your last:

Mammogram _____ Pap smear _____ Colonoscopy _____

Prostate Exam _____ Eye Exam _____ Birth Control? _____

Have you had any routine diagnostic studies? (Please Attach Reports)

Lab work _____ Chest X- ray _____

EKG _____ Endoscopy _____

Cardiology Tests _____ Other: _____

Have you attended an information seminar by one of our doctors?

Will you, the patient, commit to careful follow-up with us for up to 5 years?

□ Yes □ No

_____

Signature of Patient ***Date***

CalvertHealth™
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Consent to Care and Treatment

Patient Name: _____ DOB: _____

As a patient, you have the right to be informed about the state of your health and any recommended medical, diagnostic or surgical procedure that will be used in the course of your care at this practice so that you may make informed decisions as to whether or not to undergo any recommended treatment.

If you have been a patient of this practice prior to signing this consent, any medical conditions and/or treatment plans have already been discussed with you and you consent to the ongoing care and treatment that has been defined.

If you are a new patient with this practice, no specific treatment plan has yet been recommended.

This consent form gives us your permission to examine you and perform the evaluations necessary to evaluate your health and identify any conditions that may be affecting it. It also gives us your consent to recommend appropriate treatment for any conditions identified during the course of your care and treatment.

By signing this consent, you are giving us your permission to perform reasonable and necessary medical examinations and testing in order to assess your health and recommend treatment. You authorize this practice, your assigned physician and/or advanced practice clinician (Nurse Practitioner or Physician Assistant), and any employee working under the direction of the physician or other advanced practice clinician, to provide medical care to you. This medical care may include services and supplies related to your health and may include but not limited to preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the prescribing of drugs, devices, equipment or other items required to diagnose and treat a medical condition. This consent includes contact and discussion with other health care professionals who may be consulted regarding your care and treatment.

You are also indicating that you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain fully effective until it is revoked in writing.

You have the right at any time to discontinue services. You have the right to discuss the purpose, potential risks and benefits of any test ordered for you in the course of your treatment plan with your physician or health care provider. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

If additional testing, invasive or interventional procedures are recommended, you will be asked to read and sign additional consent forms specific to the test(s) or procedure(s) to be performed.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____
Patient Signature (or Guardian if signing for another person) Date

_____ _____
Name of Guardian Relationship to Patient

_____ _____
Witness Witness Name (please print)

CalvertHealth
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Patient Privacy Policy

The Right to Obtain a Copy of this Notice. You have the right to a paper copy of this notice at any time. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, please ask at registration or contact our Privacy Officer at the address or phone number located at the end of this document. You may obtain a copy of this notice at our website, www.CalvertHealthMedicalGroup.org.

Your Rights Regarding Your Protected Health Information. We are required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of the Notice currently in effect. We reserve the right to change our privacy practices and this notice. We reserve the right to make the revised or changed notice effective for your PHI we already have as well as any information we receive in the future. We will post a copy of the current notice. The notice will always contain on the first page, the effective date of the Privacy Notice.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with us and the Secretary of the Department of Health and Human Services. All complaints must be in writing and sent to the address provided at the end of this notice. You will not be penalized for filing a complaint.

Contact Information
If you require further information about this Notice, have privacy issues or believe that your privacy rights have been violated, please contact:

CalvertHealth Medical Group
Attn: Privacy Officer
100 Hospital Road
Prince Frederick, MD 20678

Effective Date
This Notice is effective January 1, 2020.

By signing this document, I acknowledge that I have read and understood this Privacy Notice and that a copy of CalvertHealth Medical Group' Privacy Notice was offered to me.

Patient Signature	Date
Print Name	DOB

CalvertHealth™
Medical Group

Patient Financial Policy

Patient Name: _____ DOB: _____

Thank you for choosing CalvertHealth Medical Group (CMHG) as your health care provider. We are committed to building a successful provider-patient relationship with you and your family. Please understand that payment of your bill is part of your care. This Patient Financial Policy is intended to help avoid misunderstandings by detailing your financial obligations.

Insurance: Please confirm your provider is enrolled with your insurance carrier prior to scheduling your visit.
We participate in most insurance plans, including Medicare. If you are not insured by a plan we accept, or if you choose to submit your claim yourself, payment in full is expected at each visit. We will provide you with appropriate documentation so that you can submit a claim to your insurance company.

If we do participate in your plan, but you do not have a **current insurance card or the designated primary care provider** is not a CHMG provider, payment is required in full for each visit until we verify coverage. Alternatively, if we do not participate in your insurance plan and you choose to see our providers, or if you do not have insurance and choose to see our providers, you will be considered 'self-pay' subject to the terms defined later in this document.

Proof of Insurance: If you have insurance and we submit claims on your behalf, we require a copy of your driver's license or other government issued photo ID and your current insurance card at each visit. This information must be provided prior to seeing a provider (physician, nurse practitioner or physician assistant).

Claims Submission: Your insurance benefit is a contract between you and your insurance company, and the charges for any services provided are your responsibility. We will submit claims to your insurance (primary and secondary or supplemental) company on your behalf. In order to submit claims, we require the patient's name, address, and date of birth, as well as the policyholder's name, address, and date of birth. This information must match exactly what your insurance company has on file for you, including exact name, address, and policy number. Any missing or incorrect information provided may result in claims being denied or reimbursement being delayed, in which case you may become responsible for the full amount of the services provided.

Coverage Changes: Please notify us before your scheduled appointment if any of your insurance information has changed. This includes changes of employer, insurance provider, address, policy number, covered dependents, etc. Not having up-to-date information may result in claims being denied or delays in reimbursement in which case you will become responsible for the full amount of the services provided.

Co-Payments: If your insurance company requires co-payments, those co-payments must be paid at the time of service. We collect co-pays during appointment check in.

Deductibles and Out-Of-Pocket Expenses: We will bill you for any outstanding balance once your insurance company has processed your claim and made payment to us. This balance may include your contracted deductible or other out-of-pocket expense as determined by your insurance policy. Payment for outstanding balances is expected within 30 days of the statement date and/or at your next appointment.

Referrals: It is your responsibility to obtain any necessary referrals from your primary care provider prior to receiving treatment. Patients who elect to receive service without a proper referral will be required to sign a waiver and will be expected to pay for the service prior to treatment.

Payment: We accept payment by cash, debit card, check, VISA, MasterCard, Discover, and American Express. All outstanding balances must be paid at time of service unless prior arrangements/payment plans have been set up. As a convenience to our patients, all CHMG practices are able to collect payments for all other CHMG practices.

Returned Check Fee: We charge a $25.00 fee for returned checks. In the event a check has been returned the patient must pay by credit card or cash. If a second check is returned, in addition to the returned check fee, you will be asked to pay by cash, money order, cashiers' check, or credit card for all future visits.

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Self-Pay: A Self-Pay patient is any patient who does not have health insurance; chooses to submit their own claims, see a CHMG provider who does not participate in their health insurance plan, receive a service that requires a referral from their insurance company or primary care provider when they do not have the referral with them or receives a treatment they know is not covered by their insurance company.

Financial Assistance: The Practice has payment plans, financial assistance, and sliding fee scale, to uninsured and others with self-pay balances. Please ask the office assistant for further information.

Non-Payment: If a balance remains unpaid past 90 days your account will be transferred to a collection agency or collection attorney. In the event your accounts remain in delinquent standing with the collection agency, you may be terminated from the medical group.

Minor Patients: Any adult (parent or guardian) accompanying a minor child to their appointment is responsible for payment for all services rendered to the minor child at the time of the appointment.

Physicals: Department of Transportation (DOT), 500, sports, camp and work physicals are not usually covered by any insurance companies. Payment for these services are expected at the time of service.

Personal Injury Claims: CHMG will bill the current health insurance for treatment covered by the insurance company. All applicable co-pays will be collected at time of service.

Account Consultation: Providers (physicians, nurse practitioners, physician assistants) are not trained to discuss financial issues with patients. Only CHMGs billing staff is trained to discuss your account, including charges, fees, payments, and payment arrangements. If you have questions about any of the financial issues related to your account, please contact the **billing office at 410-414-4555.**

Worker's Compensation: Prior authorization is required from your employer before service can be provided. We require the following information for each claim submitted on each date of service: state where injury occurred (i.e. Maryland); date of injury; exact location on the body where the injury occurred and that is covered by the claim. If the claim is denied and you do not have health insurance, the charges will become your responsibility.

CHMG Billing Contact Information:

Physical Address
CHMG Billing Office
Prince Frederick, MD 20678
Billing Phone Number: 410-414-4555

Mailing Address
CHMG Billing Department
PO Box 11759
Newark, NJ 07101-4759

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our financial and payment policy.

My signature below certifies that I have read, understand, and agree to the terms of this Patient Financial Policy.

Patient Signature: _____ Today's Date: _____

Patient Name: _____ DOB: _____

CalvertHealth
Medical Group

No-Show and Late Cancellation/Reschedule Policy

Patient Name: _____ DOB: _____

Thank you for choosing CHMG as your health care provider. We are committed to building a successful provider-patient relationship with you and your family. We understand there are times when you must miss a scheduled appointment or cannot cancel or reschedule in a timely manner; however, when you do not call to cancel a scheduled appointment at least 24 hours prior to the appointment or miss a scheduled appointment without notice, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise when another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

To help avoid misunderstandings, we are providing you with our No Show and Late Cancellation/Reschedule Policy. For purposes of this policy, a late cancellation is when a patient cancels or reschedules a scheduled appointment but provides less than 24 hours' notice. Late cancellations will be treated as a 'no-show' per CHMG policy.

The following policies will apply to 'no-shows' and late cancellations/reschedules, combined, on a rolling 12 month period.

'No-Shows' and late cancellations/reschedules for Office Visits:

- First offense will prompt a warning letter to the patient regarding their no-show or late cancellation/ reschedule occurrence and a notation will be made in the patient's chart.
- Second offense will prompt a phone call from the practice to the patient and 2nd warning letter will be sent to the patient.
- Third offense will prompt the patient to be discharged from the practice. The patient will receive a letter of discharge by certified mail and the patient portal.

'No-Shows' or late cancellations/reschedules for Procedure:

- Patient will automatically be charged a $100 'no-show' or late cancellation/reschedule fee. The practice staff will print a copy of the signed No-Show and Late Cancellation/Reschedule Policy along with the fee ticket, and mail to the patient.

Additional Information:

The No-Show and Late Cancellation/Reschedule Policy is not provider specific but applies across all CHMG practices, such that a no-show or late cancellation/reschedule for one provider could impact the patient's ability to schedule appointments with another CHMG provider. **For a listing of all CalvertHealth Medical Group providers and practices, please go to CalvertHealthMedicalGroup.org.**

All applicable no-show and late cancellation/reschedule fees must be paid prior to scheduling future appointments with any CHMG provider.

My signature below certifies that I have read, understand and agree to the terms of the No Show and Late Cancellation/Reschedule Policy.

Patient Signature: _____ Today's Date: _____

CalvertHealth
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Patient Portal Access

The CalvertHealth Medical Group Patient Portal is a key component of managing your health. The Patient Portal is a secure, online tool that lets you communicate with your healthcare team and manage your health information.

Using the Portal, you can:

- Review lab results;
- Review your medical history;
- Request medication refills;
- Request appointments;
- Request Referrals;
- Pay your CHMG bill;
- Send your provider or practice questions.

THE PATIENT PORTAL IS THE PRIMARY METHOD CHMG AND YOUR PROVIDER USE TO SHARE IMPORTANT INFORMATION WITH YOU!

We will send you secure communications through the portal to:

- Remind you of upcoming appointments
- Notify you of new providers
- Notify you of departing providers
- Notify you of changes to office opening and closing times (i.e. for inclement weather)

We no longer send notifications by regular mail. All communications will be by portal message, text message or telephone.

Patients who do not sign up for and activate their Patient Portal access will miss out on key communications and not be able to take advantage of this secure, online access to your medical records, medication refills, lab results, and provider communications.

When you check in for your appointment, we will ask for your email address and give you a token that you will use to activate your access. You will have 30 days from the date you receive it to go online to nextmd.com to enter the token and activate your access.

WE ENCOURAGE YOU TO ACTIVATE YOUR PORTAL ACCESS AS SOON AS YOU GET HOME.

Once you have activated your portal access, you can click on 'My Chart' then 'Request Health Records' to start downloading your medical records into your portal.

The Patient Portal is a convenient, secure way to communicate with your provider, manage your medications and monitor your health records. Please sign up and activate your portal access today.

CalvertHealth
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Patient Ethnicity and Race Form

Patients Name: _____ Date of Birth: _____ MRN: _____

The State of Maryland is requesting CalvertHealth Medical Group inquire about the ethnicity and race for each patient in order to be in compliance with the Patient Centered Medical Home. **Patient is not required to complete this form. If this form is not complete, the staff will input "Not Specified".**

Question 1. Ethnicity
Are you Hispanic or Latino?
(A patient of Cuban, Mexican, Puerto Rican, South or Central America, or other Spanish culture of origin, regardless of race.)

☐ Yes ☐ No ☐ Unknown/Not Specifying

Question 2. Please circle the racial category with which you most closely identify by placing an 'X' in the appropriate box.

RACIAL CATEGORY	DEFINITION OF CATEGORY
American Indian or Alaska Native	A patient having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.
Asian	A patient having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.
Black or African American	A patient having origins in any of the black racial groups of Africa.
Native Hawaiian or Other Pacific Islander	A patient having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
White	A patient having origins in any of the original peoples of Europe, the Middle East or North Africa.
Multi-Racial	A patient having origins of more than one Racial Category identified above.
Unknown/Not Specifying	A patient whose race is unknown OR a patient who does not wish to supply race information.

Information obtained from the Office of Management and Budget.