

ESA SOUTH JERSEY BARIATRICS

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: M F

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ SS#: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Marital Status: Single Married Divorced Separated Widowed

Race: Asian Black/African American White/Caucasian Other: \_\_\_\_\_ Declined

Ethnicity: Hispanic Non-Hispanic Declined

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Pharmacy Name & Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Primary Care Doctor Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

PRIMARY INSURANCE CARRIER: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Subscriber for Insurance: \_\_\_\_\_ Subscribers DOB: \_\_\_\_\_

Subscribers SS#: \_\_\_\_\_ Subscribers Employer: \_\_\_\_\_

SECONDARY INSURANCE CARRIER: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Subscriber for Insurance: \_\_\_\_\_ Subscribers DOB: \_\_\_\_\_

Subscribers SS#: \_\_\_\_\_ Subscribers Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

*I certify the information provide above is correct. My signature on this form authorizes the release of medical information necessary to process insurance claims to your insurance company and or their agencies as required or necessary for claims processing and payment. By signing below, I authorize payment for claim to be directly dispersed to ESA South Jersey Bariatrics and or its providers of service. I am aware that any charges deemed payable by me according to my insurance policy and processing of claim will be my responsibility. I have been informed that interest will accrue on unpaid balances and that all past due balances without payment monthly will be sent to a collection agency. (I permit a copy of this to be used in place of original as needed.)*

Patient Signature Required: \_\_\_\_\_ Date: \_\_\_\_\_

## MEDICAL HEALTH HISTORY

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

What current symptom, problem or reason are you here for today?

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Do you have any **Drug Allergies**? NO YES

If yes Drug Name: \_\_\_\_\_ Reaction: \_\_\_\_\_

Do you have any **Non-Drug Allergies**? NO YES

If yes Drug Name: \_\_\_\_\_ Reaction: \_\_\_\_\_

### MEDICATIONS (You are currently taking)

DRUG NAME	DOSE	CONDITION / REASON FOR TAKING

IF YOU ARE NOT TAKING ANY MEDICATION CHECK HERE \_\_\_\_\_ I AM CURRENTLY NOT TAKING ANY MEDICATIONS.

### PAST MEDICAL HISTORY: Please Circle all that apply

Arthritis: Osteoporosis Rheumatoid	Gall Bladder Problems	Kidney Problems
Asthma / COPD	GERD / Reflux	Liver Problems
Bowel / Bladder Abnormalities	Headaches	Implants: Type _____
Cancer type: _____	Heart Disease	Pain: Arm Back Knee Le
Chest Pain / Angina	Heart Palpitations	Seizures
Diabetes: Type I Type II	Hemorrhoids	Sleep Apnea
Diarrhea	Hernia	Stroke / CVA / TIA
Diverticulitis	High Cholesterol	Thyroid Disease
Dizziness / Fainting	Hypertension	Other: _____

Is there any other past health information we should know about?

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### SURGICAL HISTORY

TYPE OF SURGERY	DATE WHEN PERFORMED	SURGEONS NAME

## FAMILY HISTORY

CONDITIONS	MOTHER	FATHER	SISTER	BROTHER	AT WHAT AGE?
Arthritis Osteoporosis Rheumatoid					
Cancer: Type					
Depression					
Diabetes Type 1 (childhood onset)					
Diabetes Type 2 (adult onset)					
Epilepsy (seizures)					
Heart Disease: Heart Attack or Coronary Artery					
High Cholesterol (Hyperlipidemia)					
High Blood Pressure (Hypertension)					
Kidney Disease					
Migraine Headaches					
Stroke / TIA					
Thyroid Disease					

## SOCIAL HISTORY: Must answer all questions below (Circle all that apply)

**Circle One:** Employed Unemployed Homemaker Student Retired Disabled

**Employer:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_

**Status:** Full-time Part-time

**Marital Status:** Single Married Separated Divorced Widowed

**Number of Children you have:** \_\_\_\_\_

### Hobbies Recreation: *circle all that apply*

Board Games	Fishing	Painting	Shopping
Boating	Gardening	Photography	Traveling
Crafts	Hunting	Reading	Watching TV
Card Games	Motor Cycling	Sports: Watching	Walking
Computer Games	Musical Instrument	Sports: Playing	

### Exercise: *circle all that apply*

Aerobics Cross-Training Cycling Dancing Running Swimming Walking Weight lifting

OTHER: \_\_\_\_\_

### How often do you exercise?

Weekly (How many days?) 1 2 3 4 5 6 7

Time in Minutes: 15 20 25 30 35 40 45 50 55 60

## VACCINATION RECORD

Vaccination Type	YES or NO	WHEN	WHERE
Flu Vaccination	YES NO		
Pneumonia Vaccination	YES NO		

Covid 19 Vaccination	Not Vaccinated	I have chosen not to be vaccinated for personal reasons		
Vaccination Type	BRAND TYPE	YES or NO		When & WHERE
Covid 19 Vaccination	Pfizer	YES	NO	
Covid 19 Vaccination	Moderna	YES	NO	
Covid 19 Vaccination	J & J Janssen	YES	NO	
Covid 19 Vaccination	Booster	YES	NO	

Do you have any Cultural/Religious Customs / Barriers? NO YES

if yes list: \_\_\_\_\_

Do you have any impairments? NO YES *Circle applicable* Learning Hearing Physical Speech Vision

Do you have an Advance Directive? YES NO if No Would you like Information? NO YES

Do you have a Living Will? YES NO if No Would you like Information? NO YES

#### TOBACCO & ALCOHOL USE

Are you currently a smoker? YES NO *Circle applicable* Cigar Cigarettes Vaping **How often?** \_\_\_\_\_

Do you drink Alcohol? Yes NO *Circle applicable* Beer Wine Mixed Drinks **How often?** \_\_\_\_\_

**SUPPLEMENTS:** Appetite Suppressants Ginseng Fat-burners Multivitamins **Other** \_\_\_\_\_

#### SUBSTANCE ABUSE HISTORY:

Do you currently use recreational drugs? *Circle applicable* Cocaine Heroin Marijuana Other: \_\_\_\_\_

Have you had or do you have any drug addiction? YES NO Amphetamines Barbiturates Heroin Cocaine

List any other recreational drugs you are using: \_\_\_\_\_

**MENTAL HEALTH HISTORY:** *Have you ever been diagnosed with any of the following disorders?*

Anxiety Disorder	NO	YES	Type:	When:
Eating Disorder	NO	YES	Type:	When:
Mood Disorder	NO	YES	Type:	When:
Personality Disorder	NO	YES	Type:	When:
Sleep Disorder	NO	YES	Type:	When:

**COMMUNICALBE DISEASE HISTORY:** Have you ever been diagnoses with any of the following: *Circle all that apply*

AIDS Gonorrhea Hepatitis A Hepatitis B Hepatitis C Herpes

HIV HPV Measles Mumps Syphilis TB/Tuberculosis

# Patient Portal Authorization Agreement

Name: \_\_\_\_\_ Account number: \_\_\_\_\_

Email: \_\_\_\_\_

## Purpose of this Form

ESA South Jersey Bariatrics offers secure electronic access to your medical record and secure electronic communications between our office and you for those patients who wish to participate. Secure messaging can be a valuable communications tool, but certain precautions should be used to minimize risks. In order to manage these risks we have imposed some terms and conditions of participation. Your signature on this form will demonstrate that you have been informed of these risks and the conditions of participation and that you accept the risks and agree to the conditions of participation.

## How the Secure Patient Portal Works

A secure web portal is a webpage that uses encryption (a form of electronic security) to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the Portal site. Using the connection channel between your computer and the Web site, you can read, view, or send information on or from your computer. It is automatically encrypted in transmission between the Web site and your computer.

## How to Participate

You may compose, pick up, and reply to secure messages or view information sent to you through the Patient Portal. Once you have reviewed, agreed to, and signed our policies and procedures regarding use of the Patient Portal, we will assign you a username and password. You may then login to the Patient Portal through our website at <http://www.esasjbariatrics.com> or directly by going to [www.gotomyclinic.com/esasjbariatrics](http://www.gotomyclinic.com/esasjbariatrics).

## Protecting Your Private Health Information and Risks

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. However, no transmission system is perfect. We will do our best to maintain electronic security. Keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to have access to it. You are responsible for ensuring that we have your current email address and you agree to inform us immediately if it changes. Protect your username and password information as you would protect your banking information. Safeguard this information so that only you or someone you authorize has access to this information. If you believe someone has learned your password, you should immediately go to the Web site and change it. You agree not to share your username and password with unauthorized persons and to maintain that username and password in a secure place at all times. Access to the Patient Portal is a free service but we reserve the right to change this policy if needed. We strive to keep all of your protected health care information completely confidential. Please read our Notice of Privacy Practices for additional information on uses and disclosures.

## Conditions of Participating in the Patient Portal

Access to the secure web portal is a service, and we may suspend or discontinue it at any time and for any reason. If we do suspend or discontinue this service, we will notify you as promptly as we reasonably can. You agree to not hold ESA South Jersey Bariatrics or any of its staff or physicians liable for network or security infractions beyond their control. By signing this agreement, you acknowledge that you understand the policies and procedure, agree to comply with them and all of your questions have been answered to your satisfaction. If you do not understand, or do not agree to comply with our policies and procedures, do not sign this agreement and do not request a username and password. If you have question's we will gladly provide more information.

## Patient Acknowledgement

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

## Authorization for Release of Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Cell: \_\_\_\_\_

\_\_\_\_\_ I authorize ESA South Jersey Bariatrics to release information to:

\_\_\_\_\_ I authorize the release for information to ESA South Jersey Bariatrics from:

Name of Provider of Facility	
Address	
City, State, Zip Code	
Fax	
Telephone	

**PURPOSE OF THIS REQUEST:** \_\_\_\_\_ Healthcare \_\_\_\_\_ Insurance Coverage \_\_\_\_\_ Personal Other: \_\_\_\_\_

**SPECIFIC INFORMATION AUTHORIZED:** (select one or more as appropriate)

- ☐ Assessments                      ☐ Progress Notes                      ☐ Laboratory Test Results:  
☐ Diagnostic Impression                      ☐ Discharge Summary                      ☐ Treatment Plans  
☐ Treatment Summary                      ☐ Drug/Alcohol Treatment & Evaluation  
☐ Psychiatric/Psychological Treatment & Evaluation  
☐ Other: (please describe) \_\_\_\_\_

This authorization will expire: (Select One)

\_\_\_\_\_ When I am no longer receiving services from ESA SJ Bariatrics.

\_\_\_\_\_ One time use for this requested information Once requested information has been sent or received.

I understand that:  
I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment.  
I may cancel this authorization at any time by submitting a written request to the ESA SJ Bariatrics, except where a disclosure has already been made in reliance on my prior authorization.  
If the person of facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.  
If the authorized information is protected by Federal Confidentiality Rules 42CFR, Part 2, it may not be disclosed without my written consent unless otherwise provided for in the regulations. Release of HIV-related information requires additional information.

Signature of Patient or Representative: \_\_\_\_\_ Date: \_\_\_\_\_

\*If not the patient: Relationship to Patient: (Circle one)

Parent                      Legal Guardian                      Spouse                      Other: \_\_\_\_\_

ESA SOUTH JERSEY BARIATRICS, PA  
1103 WEST SHERMAN AVENUE BUILDING 2 UNIT C VINELAND, NEW  
JERSEY 08360

Date: \_\_\_\_\_

Dear Patient:

Appointments are in high demand, and your early cancelation will give another patient the possibility to have access to timely medical care.

If you are unable to make your appointment, please be courteous and call at least 24 hours prior to your appointment time to cancel. We have 24 hour answering service that enables you to call and cancel at any time.

If you do not contact our office to cancel this appointment 24 hours prior to your appointment than you will be charged a fee of \$50.00.

We do understand that an emergency may occur from time to time, resulting in the need to reschedule an appointment, and we want to remind you of the importance of preventative and follow up care as indicated by your physician.

If you fail to call and cancel your appointment 3 times you will be dismissed from our practice.

I attest that I have been informed of the fee that is involved if I fail to cancel my appointment in the 24 hours prior to my Visit.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_

# ESA South Jersey Bariatrics, PA

Compliance with the Pre-operative policy will be monitored and addressed. Patients considering bariatric surgical options must have been provided with knowledge and tools needed to achieve such lifelong lifestyle changes and must be capable and willing to undergo changes.

## Pre-Operative Policy

- Patient need to be seen for initial bariatric consultation. If medical necessity is established upon this visit, patient needs to follow insurance requirements for bariatric surgery.
- Patient needs to make two months mandatory follow up appointment with the doctor, so that the doctor can monitor patient's progress.
- After gathering all necessary requirements for bariatric surgery and once the office receive the authorization for the surgery, the patient will then be required to make another appointment for scheduling.
- Once patient is given their surgery date, they are also due to come back prior to surgery date as final pre-operative appointment. Result of pre surgical testing will be reviewed on this visit. • Smoking cessation: Patient should cease tobacco use and be smoke free six months prior to proposed bariatric procedure. Note that some insurance requires patient to be smoke free one year prior to surgery. A Nicotine test will be ordered prior to surgery.
- Patient should not be treated for any substance abuse one year prior to surgery.
- Women should not get pregnant for one year after bariatric surgery.

Appropriate postoperative care for the bariatric surgery patient is required. Follow up appointments after the surgery are required.

## Post-Operative Care

- Post-operative care by the operating surgeon one week after the surgery.
- At least three follow up visits with the operating surgeon within the first year.
- Lifetime postoperative care for dietary issues, exercise and lifestyle changes reinforced by counseling or supervised by a physician knowledgeable in the long-term care of such patients.
- Tobacco use and Alcohol consumption are prohibited after the surgery.

Patient Name: \_\_\_\_\_ Patient Signature: \_\_\_\_\_

Doctors Name: \_\_\_\_\_ Doctors Signature: \_\_\_\_\_

Date: \_\_\_\_\_



ESA SOUTH JERSEY BARIATRICS, PA

Informed Consent

**Patient considering bariatric surgical options must have been provided with knowledge and tools needed to achieve such lifelong lifestyle changes and must be capable and willing to undergo changes. Patient will be educated with the importance of compliance with the pre-surgical and post-surgical diets.**

I have been educated and I am willing to comply with my surgeon's recommended diet nutrition plan before and after surgery. I have been educated on the importance of proper calorie intake. I was instructed to exercise and increase my physical activity. I was instructed to follow up with a registered dietitian for supervised nutrition program.

I am aware that I have to follow a "Very Low Energy Diet" at least 2 weeks prior to my surgery. The goal of the diet is for me to consume approximately 800 calories and 80 grams of protein daily. Following a "Very Low Energy Diet" at least 2 weeks pre-surgery can reduce liver volume, thus making the surgical procedure easier for the surgeon, and reduce bleeding and recovery period.

After weight loss surgery, I am aware that I need to make changes on my eating patterns. Especially in the first five weeks after surgery, I need to change my eating habits to avoid pain and vomiting, rupture of staple lines, obstruction, blockage, and to aid in weight loss. I am aware of the importance of complying with the Diet stages after surgery.

I am aware that I must also do my part by following my surgeon's orders implicitly to achieve desired outcomes.

Patient Name: \_\_\_\_\_ Patient Signature: \_\_\_\_\_

Doctors Name: \_\_\_\_\_ Doctors Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## ESA SOUTH JERSEY BARIATRICS

### INFORMATIVE NOTIFICATION FOR BARIATRIC SERVICES

This notification is to inform you that all insurances have different requirements that are based on the individual contracts within a specific insurance company and also varies based upon the employee's group selection of benefits.

- Bariatric services have diagnosis of E66.01 Morbid Obesity or E66.9 Obesity
- Co-Morbidities: 110 Hypertension, E11.9 Diabetes, G47.33 Sleep Apnea
- These diagnoses are useful for gaining authorization based on medical necessity when your BMI is not in the range to qualify.
- Procedures include: 43775 Gastric Sleeve  
43644 Lap. Gastric By-pass  
S2083 Gastric Lap-Band Adjustment
- Please make note that these services may or may not be covered by your insurance. We strongly advise you to contact your insurance company and ask if they cover the above services with the diagnosis listed. \* Be advised that plan do have requirements that must be met and we will gather this information after eligibility has been determined.
- Post-Surgical Care:  
Patients have a 90-day global period for their original surgical procedure.  
After the global period has ended services are than billable.  
The Gastric Lap-band adjustments have no global days and will be billable.

Please also make note that once a patient's BMI is below 38, your diagnosis will change to E66.9 and your insurance may deny coverage based on medical necessity.

**In signing this notification, you are acknowledging that payment for services rendered will become your responsibility should your insurance deny payment of benefit. \* *Copy given to patient***

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**ESA SOUTH JERSEY BARIATRICS, PA**

1103 West Sherman Avenue  
Building 2 Unit C  
Vineland NJ 08360

**Medical Information Release Form**

(HIPAA Release Form)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Release of Information**

I authorize the release of information including the claims information, diagnosis, records and examination rendered to me.

☐ This information may be release to:

Spouse \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Children \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Other \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

☐ Information is not to be release to anyone

**Messages**

Please call ☐ Home Phone # \_\_\_\_\_

☐ Work Phone # \_\_\_\_\_

☐ Cell Phone # \_\_\_\_\_

You may leave detailed message Yes No

Please leave a message asking me to return your call Yes No

The best time to reach me is (day) \_\_\_\_\_ between (time) \_\_\_\_\_

This ***Release of Information*** will remain in effect until terminated by myself in writing

Signed: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## ESA SOUTH JERSEY BARIATRICS

Name: \_\_\_\_\_

Date: \_\_\_\_\_

### Current Reason for Today's Visit

What is your reason for seeing the doctor today? \_\_\_\_\_

What are your current symptoms? \_\_\_\_\_

How long have you had these symptoms? \_\_\_\_\_ Days \_\_\_\_\_ Weeks \_\_\_\_\_ Months

### VACCINATION RECORD

**Are you vaccinated for any of the below vaccine, please answer all question and provide vaccine card**

Flu Shot? Yes No if yes Where and When: \_\_\_\_\_

Pneumonia Shot? Yes No if yes Where and When: \_\_\_\_\_

Covid 19? (circle one) NO Moderna Pfizer Johnson & Johnson's Janssen

Where & Dates: \_\_\_\_\_

### Acid Reflux or GERD

**Are you currently having any of the following symptoms of Acid Reflux/GERD?** Check below all that apply

Do you experience heartburn or acid reflux more than once a week? Yes No

Still suffer from heartburn, after taking over-the-counter or prescription medications? Yes No

Have you been taking an OTC medication longer than the product label recommends? Yes No

Are your symptoms become more severe over time? Yes No

Is your heartburn symptoms lasting longer or become more frequent? Yes No

Do you experience severe hoarseness or wheezing? Yes No

Has swallowing food or pills becomes difficult or painful? Yes No

### EMOTIONAL WELL-BEING

Are you currently feeling depressed or anxious? YES NO

If yes, explain how you are feeling? \_\_\_\_\_

Are you current being treated by a psychiatrist? YES NO

If yes, what is your clinical diagnosis? \_\_\_\_\_

If yes, are you taking any medication? YES NO

If yes, what medication are you taking? \_\_\_\_\_

Do you feel like you want to harm yourself? YES NO

If yes please explain so we can get you help: \_\_\_\_\_

**ONLY COMPLETE BELOW IF YOU ARE A Bariatric still completing requirements for surgery**

How many Nutrition Visits have you completed? 1 2 3 4 5 6

Did you complete your Support Groups? YES NO

Did You Complete the Information Session? YES NO

Have you completed your Psychiatric Evaluation? YES NO

If yes, who did you see? \_\_\_\_\_ When \_\_\_\_\_