Advanced BARIATRICS

MEDICAL WEIGHT LOSS FORM

(Please Print)

PATIENT INFORMATION

MR. MRS. MISS. MS. PATIENT'S LAST NAME	FIRST	MIDDLE	MARITAL STATUS (Circle one): SINGLE MARRIED DIVORCED SEPARATED WIDOW
IS THIS YOUR LEGAL NAME? YES NO IF NOT, WHAT IS YOUR LEGAL NAME (FORMER NAME)?		BIRTH DATE / /	AGE / SEX M F
STREET ADDRESS:	SOCIAL SECURITY # (Last 4 only) 000-00-	HOME PHONE ( )	
CITY / STATE / ZIP:	EMAIL:	CELL PHONE ( )	
OCCUPATION:	EMPLOYER:	WORK PHONE ( )	

WHOREFERREDYOUTOOUR OFFICE? FAMILY FRIEND CLOSE TO HOME / WORK INTERNET

DR. _____ INSURANCEPLAN HOSPITAL OTHER _____

PRIMARY CARE PHYSICIAN NAME/ADDRESS:

PREFERRED PHARMACY NAME AND CITY:

Race: Caucasian Asian African-American Hispanic Hawaiian/Pacific Islander Prefer not to answer

Ethnicity: Hispanic Non-Hispanic Prefer not to answer

INSURANCE INFORMATION

INSURANCE COMPANY #1	INSURED'S NAME	INSURED'S BIRTH DATE / /
INSURANCE COMPANY #2	INSURED'S NAME	INSURED'S BIRTH DATE / /

PERSON RESPONSIBLE FOR THE BILL:

IN CASE OF EMERGENCY

NAME:	HOME PHONE ( )
RELATIONSHIP TO PATIENT:	CELL PHONE ( )

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO THE PHYSICIAN. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE.** I ALSO AUTHORIZE ADVANCED SURGICAL CARE OF NORTHERN ILLINOIS TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIMS.

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

_____ _____

Name *Date*

Your answer on this form will help your health care provider better understand your medical concerns and conditions. If you cannot remember specific details, please provide your best guess. Thank You.

Date of Birth: _____ How would you rateyour general health? Excellent Good Fair Poor

Main reason for today'svisit: _____

Current Height _____ Weight_____ Other concerns:_____

MEDICAL HISTORY

Have you ever had anesthesia? Yes No Didyouexperienceanyofthefollowing:

Airway problem? Malignant hypothermia (High fever during surgery?)

Do you smoke? Yes No Former How many packs per day? Do you consume alcohol? _____How many years? _____

Yes No Quantity? Doesyourmedicalhistoryincludeanyofthefollowing (circle if _____How often? _____

applicable):

Asthma Bronchitis Anemia Hypertension/High Blood Pressure

Heart Attack Irregular Heart Beat Swelling in Emphysema Stomach Ulcer Chest pain

MitralValveProlapse hands or feet Hepatitis orjaundice JointstiffnessorArthritis Kidney problem Back pain

Diabetes or injury HeartPacemaker(pleasehavecardavailable)

Thyroidproblem Epilepsy or seizures Cancer(type):_____

Tuberculosis Stroke

Other (please specify):_____

MEDICATIONS:

Medication/Vitamin/Supplement	Dosage/Strength (e.g. mg/pill)	How many times Daily?
1		
2		
3		
4		
5		
6		
7		
8		

SURGICAL HISTORY:

Surgeries	Year of Surgery	Reason for Surgery
1		
2		
3		
4		
5		
6		
7		
8		

FAMILY HISTORY:

Check all that apply	MOTHER	FATHER	OTHER RELATIVES (please specify)
Cancer (please specify)			
Heart Disease			
Diabetes			
Stroke			
Hypertension (high blood pressure)			
Other (please specify)			

ALLERGIES: Do you have allergies or reactions to:

Medications **Reaction** **Foods** **Reaction**

_____ _____

_____ _____

WEIGHT HISTORY AND HEALTH BEHAVIORS

WEIGHT HISTORY

1. At what age did weight become a problem for you?

   o Childhood o Teens o Adulthood o Pregnancy o Menopause

2. Have there ben any circumstances or life events that have triggered weight gain for you?

   o Pregnancy o Job Change o New Medication o Stress o Boredom

   o Other _____

3. What was your weight one year ago? _____ Two years ago? _____ Five years ago? _____
4. What has been your highest weight? _____
5. What was your weight around age 20? _____
6. Have you lost weight in the past? If so, select from the list the program/method, and how much weight you lost. (Check all that apply):

   o Weight Watchers o Nutrisystem o Jenny Craig
   o LA Weight Loss o Atkins o South Beach
   o Zone Diet o Medifast o Dash Diet
   o Paleo Diet o HCG Diet o Mediterranean Diet
   o Ornish Diet o Other

7. Have you ever used any prescription medications for weight loss? (Check all that apply):

   o Phentermine (Adipex) o Meridia o Xenecal/Alli o Phen/Fen
   o Phendimetrazine (Bontril) o Topamax o Saxenda o Diethylproion
   o Bupropion (Wellbutrin) o Belviq o Qsymia o Contrave
   o Other (including supplements)
   o 7a. If so, how much weight did you lose with the medication, and did you experience any side effects?

   _____ _____

8. How is your weight affecting your health and your life? _____

   _____ _

9. What do you consider some of your barriers when it comes to managing your weight? (Check all that apply)

   o Hunger o Cravings o Fatigue o Finances
   o Time o Knowledge o Other _____

10. What are your goals/anticipated outcomes from this program? _____ _____

    _____

NUTRITION

1. How do you feel about your current eating habits?

   o Could be better o Pretty good overall but room for improvement o I have great habits

2. Are you currently following a particular eating plan? Yes No If yes, which one?

   o Low fat o Low carb o Keto o Mediterranean
   o Vegan o Other _____

3. Have you tried particular eating plans or diets in the past? Yes No If yes, which ones have you tried, and which ones worked well or did not work for you?

_____

4. Number of meals and snacks you eat on an average day:

o 3 o 3-5 o 6-8 o 8-10+

5. Food allergies / intolerances (check all that apply)

o Gluten o Dairy o Tree nuts o Eggs o Soy o Fish/Shellfish

o Other:

6. Who does most of the cooking and/or grocery shopping at your house?

o Self o Spouse/Partner o Other member of household o Other

7. Food preferences including ethical or cultural considerations: _____

_____ _____

8. How many times per week do you eat food or drink beverages from a restaurant?

o Never o 1-3x/week o 4-6x/week o More than 7x/week

9. Triggers for eating (check all that apply)

o Hunger o Stress o Boredom o Cravings

o Time of day o Other _____

10. Barriers to eating health (check all that apply) o Cooking skills o Time o Financial Reasons o Access to healthy foods o Schedule

o Home/work circumstances o Other

11. Current or past history of an eating disorder? Yes No If yes, please elaborate:

_____

PHYSICAL ACTIVITY

1. How many days a week do you engage in moderate to vigorous physical activity, such as a brisk walk or an exercise class?

o Never o 1-2x/week o 3-4x/week o 5 or more x/week

2. How many minutes does each bout of exercise typically last?

o 10 min or less o 10 min – 20 min o 20 min – 30 min o More than 30 min

3. Type of activities you participate in regularly? (check all that apply)

o Walking o Biking o Strength training o Yoga

o Other _____

4. List any barriers to physical activity. (time, joint pain, motivation, etc.)

_____

5. List equipment/spaces available to you for activity.

o Gym membership o Stationary bike o Free weights o Walking path

o Other _____

6. What types of activities do you enjoy or have enjoyed in the past? _____

_____

ALCOHOL

1. Do you drink alcohol? ☐Yes ☐No If yes, what kind? (check all that apply)
   - o Beer
   - o Wine
   - o Liquor
   - o Cocktails
2. How many drinks per week do you drink?
   - o None
   - o 1-3
   - o 4-7
   - o More than 8
3. Are you concerned about the amount you drink? ☐Yes ☐No

CALORIC BEVERAGES

1. Do you drink caloric beverages such as soda, juice, sweetened tea, or coffee with creamer?
   ○ Yes ☐No If yes, what kind? _____
2. How many ounces per day on average? _____

SLEEP

1. How many hours of sleep do you average per night?
   - o Less than 5
   - o 6-8 hours
   - o 9 or more hours
2. Do you work a night shift or shift work? ☐Yes ☐No
3. Usual bedtime: _____ Usual Waking time: _____
4. Do you have trouble falling asleep or staying asleep? ☐Yes ☐No
5. Have you ever been evaluated for sleep apnea or other sleep related disorders? ☐Yes ☐No If yes, were you diagnosed with sleep apnea? ☐Yes ☐No If yes, do you use a CPAP, BIPAP, or other device?
   _____
6. Do you snore? ☐Yes ☐No
7. Are you tired throughout the day? ☐Yes ☐No
8. Has anyone observed that you stop breathing during sleep? ☐Yes ☐No
9. Do you often wake up with headaches in the morning? ☐Yes ☐No
10. Do you take naps during the day? ☐Yes ☐No

OCCUPATION AND HOME LIFE

1. How many people live with you in your home? _____
2. If there are children in your home, please indicate their ages: _____
3. What is your occupation: _____
4. Do you have good social support for healthy lifestyle changes? ☐Yes ☐No If so, list your “support people”:
   _____

MENTAL HEALTH

1. Is stress a major problem for you? ☐Yes ☐No Rate your stress level on a scale from 1 to 10: _____
2. Do you feel like you have healthy coping mechanisms for stress? ☐Yes ☐No How do you cope with your stress? _____
3. Do you consider yourself an "emotional eater"? ☐Yes ☐No
4. Do you ever feel depressed? ☐Yes ☐No
5. Have you ever been diagnosed with a mental health condition? ☐Yes ☐No If yes, which mental health condition?
   - o Anxiety
   - o Depression
   - o Bipolar Disorder
   - o Other
6. Do you cry frequently? ☐Yes ☐No
7. Have you ever attempted suicide? ☐Yes ☐No
8. Have you ever seriously thought about hurting yourself? ☐Yes ☐No
9. Have you ever been to a counselor or other mental health professional? ☐Yes ☐No

   If yes, are you currently receiving counseling? ☐Yes ☐No

WOMEN ONLY

1. Age at onset of menstruation: _____
2. Date of last menstruation: _____
3. Do you have any of the following: heavy periods, irregularity, spotting, pain, or discharge? ☐Yes ☐No
4. Number of pregnancies: _____ Number of live births: _____
5. Are you pregnant or breastfeeding? ☐Yes ☐No
6. Are you planning a pregnancy within the next year? ☐Yes ☐No
7. Do you have any problems with urinary or bladder control? ☐Yes ☐No
8. Have you ever been diagnosed with PCOS? ☐Yes ☐No
9. Have you been affected by infertility? ☐Yes ☐No
10. Date of last pap: _____

MEN ONLY

1. Do you usually get up to urinate during the night? ☐Yes ☐No If yes, number of times: _____
2. Any difficulty with erection or ejaculation? ☐Yes ☐No

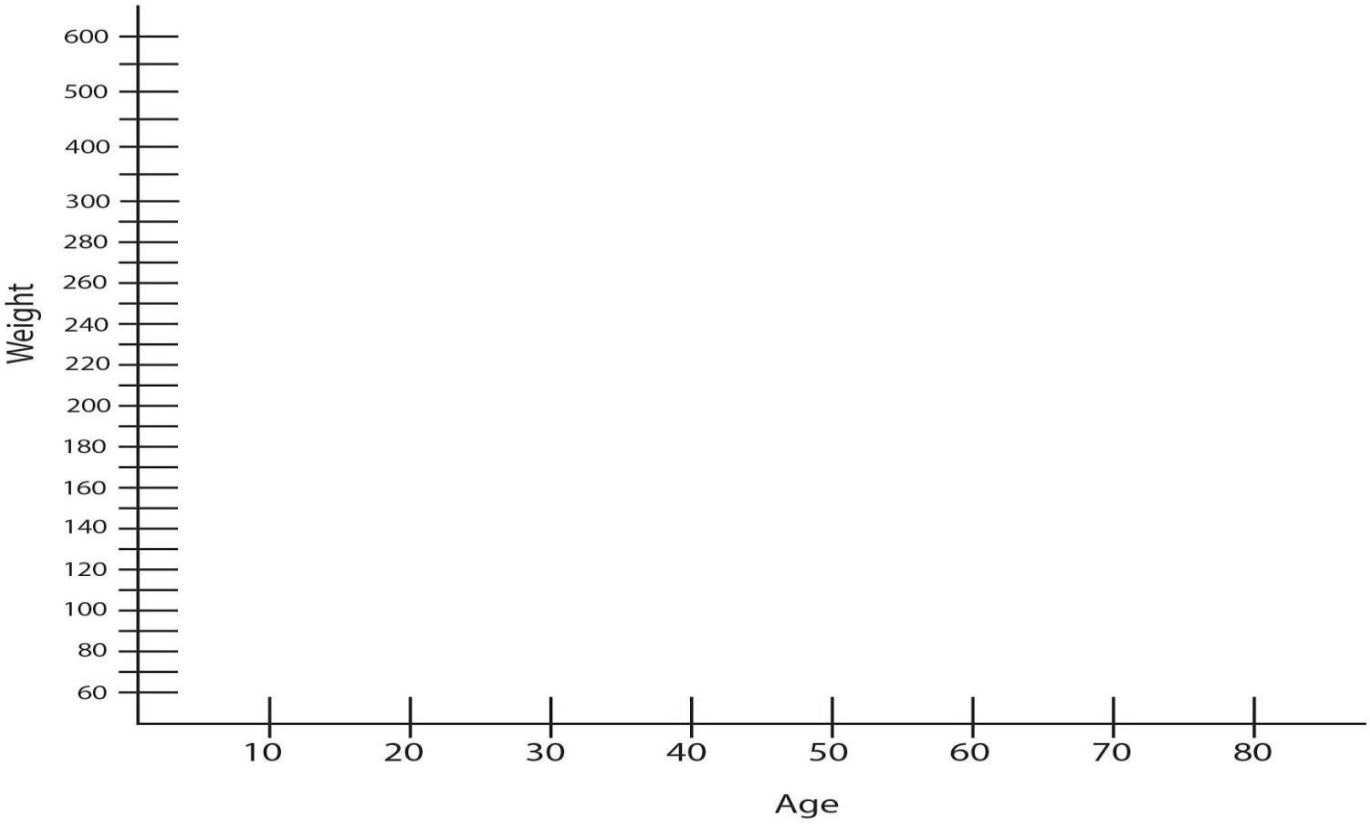
NUTRITION HISTORY

Please list your food and beverage intake for the past 24 hours.

TIME	FOOD & BEVERAGES CONSUMED	PLACE CONSUMED

WEIGHT GRAPH

Please chart your age and weight on the chart below.



Advanced
SURGICAL CARE
of Northern Illinois, LTD.

Advanced Surgical Care of Northern Illinois

APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Advanced Surgical Care. When you schedule an appointment with Advanced Surgical Care, we set aside enough time to provide you with the highest quality care. Should you need to cancel or rescheduled an appointment, please contact our office as soon as possible. This should be done no later than 24 hours prior to your scheduled appointment. If you are running late, please notify the office. If a patient arrives more than **10 minutes** past their scheduled time, our office staff will need to reschedule your appointment and our no-show policy terms will apply.

Effective January 1, 2025, any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24-hour notice will be considered a No Show and charged a **$50.00 fee**.

- Any established patient who fails to show or cancels/reschedules an appointment without 24-hour notice a **second time** will be charged a **$60.00 fee**.

- If a **third** No Show or cancellation/reschedule without 24-hour notice should occur with a year's time, the patient may be **dismissed from Advanced Surgical Care.**

- Any new patient who fails to show for their initial visit will not be rescheduled.

- These fees are the responsibility of the patient, not the insurance company, and are **due prior to the patient's next office visit.**

We understand there may be times when an unforeseen emergency may occur, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our Office Manager, who may be able to waive the No Show fee. You may contact Advanced Surgical Care during regularly scheduled office hours at the numbers below. Voicemail messages can be left, and we will attempt to call you back once received. Given the sometimes-unreliable nature of voicemail, cancellation of an appointment is not official until the patient has spoken directly with one of our staff members. We will also accept appointment cancellations via our Live Well portal.

Advanced Surgical Care 847-381-8161

I have read Advanced Surgical Care's Cancellation/No Show Policy and agree to its terms. I understand that these terms are renewable each year and do not require additional signatures in subsequent years. A paper copy of this policy is available upon request.

_____ _____ _____

Signature **Name** **Date**

Advanced Surgical Care of Northern Illinois Payment Policy

Thank you for choosing Advanced Surgical Care of Northern Illinois for your surgical needs. We are committed to providing you with quality health care and we would like you to completely understand our payment policy. A copy of our payment policy will be provided to you upon request.

1. Insurance. We participate in most insurance plans. If you are not insured by a plan, we do business with, payment in full is expected at each visit. If you are insured by a plan, we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Due to the many different insurance products available, our staff cannot guarantee your eligibility and coverage. Please be sure to check with your insurer's member benefits department about services and providers covered prior to your appointment. Many websites have erroneous information and are not a guarantee of coverage. You are responsible for requesting and obtaining a properly dated referral if required by your insurer and are responsible for payment if your claim is rejected for a lack of one.

2. Co-payments and deductibles. Payment is expected at the time of your visit. All co-payments, unmet deductibles, co-insurance, or charges not covered by your insurance must be paid at the time of service. This arrangement is part of your contract with your insurance company. Please help us in upholding the law by paying these at each visit. We will accept cash, check, or credit card.

3. Surgical Deposit. Advanced Surgical Care will collect a surgical deposit which will be due 3 weeks prior to your procedure. This is procedure specific and will be discussed with you when scheduling your procedure.

4. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payment of fees charged for these services.

5. Proof of insurance. All patients must complete our patient information form before seeing a provider. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

6. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

7. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

8. Nonpayment. If your account has a balance after your insurance has paid their portion, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Patients consent to receive phone calls and/or text messages, in compliance with HIPAA, to collect past due balances and/or marketing messages. Please be aware that if a balance remains unpaid, after 30 days, we will charge your card on file for your balance in full.

9. Returned checks will incur a $30.00 service charge. You will be asked to bring cash or certified funds to cover the amount of the check plus the $30 service charge to pay the balance prior to receiving services from our staff or providers. Stop payments constitute a breach of payment and are subject to the $30 service fee and collections action. All bad checks written to this office are subject to collections.

10. Billing office. If you have questions regarding any of our billing statements, our billing company can be contacted at.847-381-8161 option 5.

11. Your Medical Information:Your rights-Our responsibilities: Your privacy is important to us. Please inform the staff if you need another copy or have not received our privacy policy.

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 payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

Signature of Patient/Responsible Party: _____Date:_____

CONSENT FOR RELEASE OF HEALTH INFORMATION

Patient name: _____

Date of Birth: _____

Please specify if we can leave you a detailed message (circle one):	
Leave Detailed Message Yes No	Leave Detailed Lab/Test Results Yes No

*Answering machines and voice mail must have an identifying message to confirm these are your numbers for example; "You have reached John Doe"

Please list any persons with whom we **MAY** share details about your health care. Indicate below whether this may include **sensitive health information (SHI)** such as mental health, developmental disabilities, AIDS/HIV, Drug/Alcohol treatment and or Genetic testing.

I understand that this consent is valid until it is revoked by me and applies to information about me obtained through all Advanced Surgical Care locations and Physicians. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Name	Relationship	Release SHI? (circle one)
		Yes No
		Yes No
		Yes No
		Yes No

Patient Name: _____

Signature of Patient or Responsible Party if a minor: _____

Date: _____