CALLING YOUR INSURANCE COMPANY

** INCOMPLETE FORMS MAY RESULT IN A DELAY OF PROCESS**

Call the benefits coordinator at your human resource office and/or call the customer service line listed on the back of your insurance card. State "I am inquiring about my policy benefits regarding the surgical treatment of morbid obesity. Is surgery for morbid obesity a covered benefit under my policy or is it an exclusion of benefits?"

If you do have coverage, ask if this includes LAP SLEEVE GASTRECTOMY SURGERY (CPT 43775) or LAP GASTRIC BYPASS SURGERY (CPT 43644).

Finally, ask them to send you a copy of the policy or explain where a copy can be found on the surgical treatment of morbid obesity (ICD 10 code E66.01).

You may use the list below to help ask all the questions and document the answers received.

1. Name, and telephone number, and extension of representative called:____
2. Is surgery for morbid obesity a covered benefit? YES NO
3. Which CPT codes are covered? SLEEVE (43775) or GASTRIC BYPASS (43644)
4. Do you have a policy on surgery for morbid obesity that I can obtain?
5. What information do you require BEFORE authorizing the surgery?
   a. Nutrition consult required? YES NO
   b. Psychological consult required? YES NO
   c. Medical clearance from physician? YES NO
   d. Note from surgeon? YES NO
   e. Documentation of weight loss attempts? YES NO
   f. Documentation of length of obesity? YES NO
   g. Is there a medically supervised diet program required? If so what is the length; 3, 6, or 9 months?

If a preparatory program is required, you are able to complete the program with our clinic, or you may complete the program with a local provider of your choosing. If you choose to complete this outside of our clinic, PROPER documentation of completed prep program will need to be provided to our clinic PRIOR to receiving a pre-op appointment.

Please submit this form along with your completed health questionnaire and all applicable paperwork.

NORTHWEST INSTITUTE FOR DIGESTIVE SURGERY

NEW PATIENT REGISTRATION FORM

1 FULL LEGAL NAME			PREVIOUS LAST NAME
LAST	FIRST	M.I	

2 DATE OF BIRTH	MARITAL STATUS	GENDER	SSN
	❑ SINGLE ❑ MARRIED ❑ WIDOWED ❑ DIVORCED	❑ M ❑ F	
MM-DD-YYYY			XXX-XX-XXXX

3 ADDRESS			
STREET OR PO BOX	CITY	STATE	ZIP

4 CONTACT INFORMATION: (PLEASE CHECK YOUR PREFERRED CONTACT NUMBERS)			
❑ CELL PHONE	❑ HOME PHONE	❑ WORK PHONE	❑ E-MAIL

5 PREFERRED PHARMACY					
NAME	STREET	CITY	STATE	ZIP	PHONE

6 EMERGENCY CONTACT		
NAME	RELATIONSHIP	PHONE

7 LIST PRIMARY CARE PHYSICIAN & OTHER PHYSICIANS YOU SEE		
NAME	SPECIALTY	PHONE

NEW PATIENT REGISTRATION FORM

NORTHWEST INSTITUTE FOR DIGESTIVE SURGERY

9 INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME	ID#	GROUP #	PHONE #
SUBSCRIBER – EMPLOYEE NAME	DOB (MM-DD-YYYY)	SSN	RELATIONSHIP TO PATIENT
SECONDARY INSURANCE COMPANY NAME	ID#	GROUP #	PHONE #
SUBSCRIBER – EMPLOYEE NAME	DOB (MM-DD-YYYY)	SSN	RELATIONSHIP TO PATIENT

10 GUARANTOR INFORMATION

LAST	FIRST	MI	RELATIONSHIP TO PATIENT

11 DEMOGRAPHIC INFORMATION

☐ DECLINE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN

☐ WHITE ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ OTHER:

12 ETHNIC INFORMATION

☐ DECLINED ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO

13 PREFERRED LANGUAGE

☐ ENGLISH ☐ FRENCH ☐ RUSSIAN ☐ ARABIC ☐ GERMAN ☐ SPANISH ☐ CHINESE ☐ JAPANESE ☐ VIETNAMESE

☐ OTHER:

I hereby authorize any insurance benefits to be paid directly to Northwest Specialty Hospital. I understand that I am responsible for paying non-covered services. I hereby authorize the release of pertinent medical information to my insurance carriers and to such other organizations as may be permitted under the Health Insurance Portability and Accountability Act (HIPAA). I have verified that demographics information sheet to be true and correct.

SIGNATURE (PATIENT OR GUARDIAN) DATE RELATIONSHIP TO PATIENT

Date of birth	Height	Weight	BMI
Drug / Food Allergies:			

Weight Management History (Details are crucial in order to obtain insurance benefits)			
			First time obesity? ☐ Yes ☐ Lifelong ☐ High School ☐ After Children ☐ Later
Current Weight	Maximum Weight	Weight at High School Graduation	
Please provide a **brief** summary of your history with obesity:			

Biggest issues with eating include: ☐ Snacking ☐ Grazing ☐ Big meals ☐ Too many meals ☐ Unhealthy food choices ☐ Binging ☐ Starvation ☐ Other:

Which bariatric surgery are you most interested in? And why?

How long have you been considering bariatric surgery?

Attempted Diets:	Year	For how long?	Weight lost	Weight gained
Slim Fast				
Jenny Craig				
MediFast / OptiFast				
Hypnosis				
Overeaters Anon.				
Acupuncture				
Weight Watchers				
Other(s):				

Medication	Dosage	Frequency

Previous Surgeries (please provide year it was done):

Social History				
Occupation:			How long?	
Tobacco Use: ☐ Never	☐ Current → Packs per day?		☐ Former → Quit date	
Alcohol Use: ☐ Never	☐ Social	☐ Seldom	☐ Frequent	☐ Former
Drug Use: ☐ Yes ☐ No	Which one(s):			
Caffeine Use: ☐ Yes ☐ No	How many ounces per day?			
Carbonated Beverages: ☐ Yes ☐ No	How many ounces per day?			

Family Medical History			
Obesity	☐ Yes ☐ No	# of deaths related to obesity?	
Heart Disease	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Bleeding Disorder	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Gallstones	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Malignant Hyperthermia	☐ Yes ☐ No
Type(s):			
Other:			

Personal Medical History (if yes, check appropriate boxes)

Bladder / Kidney		
☐ Blood in urine	☐ Bladder cancer	☐ Dialysis treatment
☐ Kidney Stones	☐ Loss of bladder control	☐ History of PSA test
☐ Prostate irregularity	☐ Renal failure	
Comments		

Breast		
☐ Breast cancer	☐ Fibrocystic disease	☐ Gynecomastia Lump(s)
☐ Lump(s)	☐ Pain	☐ Nipple discharge
Comments		

Constitutional		
☐ Anemia	☐ Fatigue	☐ Hair loss

Constitutional (cont.)		
☐ Insomnia	☐ Night sweats	☐ Skin changes
Comments		

Endocrine		
☐ Diabetes	☐ Elevated cholesterol	☐ Elevated triglycerides
☐ Goiter	☐ Hypoglycemia	☐ Hyperthyroidism
☐ Hypothyroidism	☐ Parathyroid	☐ Thyroid cancer
Comments		

Head / Neck		
☐ Difficulty swallowing	☐ Hearing difficulty	☐ Neck lump(s)
☐ Sinus drainage	☐ Vision disturbance	☐ Voice hoarseness
Comments		

Heart / Blood Vessels		
☐ Angina	☐ Ankle swelling	☐ Cardiac bypass
☐ Clogged arteries	☐ Congestive heart failure	☐ Heart attack Foot ulcers
☐ Foot ulcers	☐ High blood pressure	☐ Pacemaker
☐ Palpitations	☐ Raynaud's disease	☐ Varicose veins
Comments		

Immune / Blood function		
☐ Anemia	☐ Bleeding disorder	☐ HIV
☐ Low platelets	☐ Lupus	☐ Lymphoma
Comments		

Intestinal		
☐ Abdominal pain	☐ Abdominal hernia	☐ Black, tarry stools
☐ Blood in stool	☐ Cirrhosis	☐ Colitis

Intestinal (cont.)		
☐ Colon polyp(s)	☐ Crohn's disease	☐ Diarrhea
☐ Enlarged liver	☐ Fissure	☐ Gallbladder problem(s)
☐ GI cancer	☐ Hiatal hernia	☐ Heartburn
☐ Hemorrhoids	☐ Hepatitis	☐ Indigestion
☐ Irritable bowel	☐ Jaundice	☐ Pancreatic disease
☐ Rectal bleeding	☐ Ulcer(s)	
Comments		

Lung function		
☐ Asthma	☐ Bronchitis	☐ Chronic cough
☐ COPD	☐ Coughing up blood	☐ Emphysema
☐ Hypoventilation	☐ Lung cancer	☐ Pneumonia
☐ Pulmonary embolism	☐ Shortness of breath	☐ Snoring
☐ Sleep apnea	☐ Tuberculosis	☐ Use of CPAP/BiPAP
☐ Use of oxygen daily		
Comments		

Musculoskeletal		
☐ Arthritis	☐ Back pain	☐ Cancer
☐ Fibromyalgia	☐ Hip pain	☐ Joint replacement
☐ Knee pain	☐ Muscle pain / spasm	☐ Neck pain
☐ Rheumatoid arthritis	☐ Shoulder pain	☐ Problem walking/standing
Comments		

Neurological		
☐ Alzheimer's	☐ Balance problem	☐ Dementia
☐ Epilepsy	☐ Headache(s)	☐ Migraine(s)
☐ Multiple sclerosis	☐ Parkinson's disease	☐ Stroke
Comments		

NORTHWEST BARIATRICS

Obstetrics / Gynecology		
☐ Cervical cancer	☐ Currently pregnant	☐ Irregular menstruation
☐ Painful menstruation	☐ Ovarian cancer	☐ Uterine cancer
Date of last PAP smear:		
Date of last menstrual period:		
Age menses began:		
Number of pregnancies:		
Number of live births:		
Planning for more children?		
Comments		

Psychiatric		
☐ Alcoholism	☐ Anorexia	☐ Anxiety
☐ Attempted suicide	☐ Bipolar disorder	☐ Body dysmorphia
☐ Bulimia	☐ Depression	☐ Drug dependency
☐ OCD	☐ PTSD	☐ Schizophrenia
Comments		

I understand that I am responsible for obtaining pertinent medical records from my physician's offices to provide to Northwest Institute for Digestive Surgery as part of the bariatric program upon request. I have verified that medical history and information provided to be true and correct.

__________________________ Signature (Patient or Guardian)

________________ Date

____________________ Relationship to Patient

__________________________ Print patient name

NORTHWEST INSTITUTE FOR DIGESTIVE SURGERY

REFLUX QUESTIONNAIRE

Name: ____________________ DOB: ______________ Date: ____________________

Do you normally take PPIs, such as Prilosec (omeprazole), Prevacid (lansoprazole), Nexium (esomeprazole), Dexilant (dexlansoprazole), Aciphex (raberprazole), and Protonix (pantoprazole)?

☐ Twice Daily ☐ Daily ☐ Occasionally, as needed ☐ No

Have you taken PPIs in the last 7 days? ☐ Yes ☐ No

Scoring Scale						
0 = No Symptoms	3 = Symptoms bothersome every day					
1 = Symptoms noticeable but not bothersome	4 = Symptoms affect daily activities					
2 = Symptoms noticeable and bothersome but not every day.	5 = Symptoms are incapacitating – unable to do activities					
1. How is your heartburn?	0	1	2	3	4	5
2. Heartburn when lying down?	0	1	2	3	4	5
3. Heartburn when standing up?	0	1	2	3	4	5
4. Heartburn after meals?	0	1	2	3	4	5
5. Does heartburn change your diet?	0	1	2	3	4	5
6. Does heartburn wake you from sleep?	0	1	2	3	4	5
7. Do you have difficulty swallowing?	0	1	2	3	4	5
8. Do you have pain with swallowing?	0	1	2	3	4	5
9. How bad is your regurgitation?	0	1	2	3	4	5
10. Regurgitation when lying down?	0	1	2	3	4	5
11. Regurgitation when standing up?	0	1	2	3	4	5
12. Regurgitation after meals?	0	1	2	3	4	5
13. Does regurgitation change your diet?	0	1	2	3	4	5
14. Does regurgitation wake you from sleep?	0	1	2	3	4	5
15. Do you have abdominal bloating or distention?	0	1	2	3	4	5
16. Do you have a cough?	0	1	2	3	4	5
17. Do you have excess flatulence (passing gas)?	0	1	2	3	4	5
18. Do you have voice changes?	0	1	2	3	4	5
19. Do you have nausea?	0	1	2	3	4	5
20. Do you have vomiting?	0	1	2	3	4	5
21. Do you have dumping (crampy abdominal pain and diarrhea after eating)?	0	1	2	3	4	5
22. Do you have bowel urgency?	0	1	2	3	4	5
23. If you take reflux medications, does this affect your daily life?	0	1	2	3	4	5
24. Are you able to belch?	☐ Yes		☐ No		☐ Don't know	
25. Are you able to vomit if needed?	☐ Yes		☐ No		☐ Don't know	
26. Do you feel full after eating a small amount of food?	☐ Yes		☐ No		☐ Don't know	
27. How satisfied are you with your present condition?	☐ Satisfied		☐ Neutral		☐ Dissatisfied	

Total:_______

NORTHWEST BARIATRICS

Patient Name (Last, First Middle)		
Weight	Height	BMI
	☐ M ☐ F	
Age	Gender	Previously diagnosed with sleep apnea?

Do you **SNORE** loudly (louder than talking or loud enough to be heard through a closed door)?	☐ YES ☐ NO
Do you often feel **TIRED**, fatigued, or sleeping during the daytime?	☐ YES ☐ NO
Has anyone **OBSERVED** you stop breathing during your sleep?	☐ YES ☐ NO
Do you have or are you being treated for high blood **PRESSURE**?	☐ YES ☐ NO

Is your **BMI** more than 35kg/m2?	☐ YES ☐ NO	
Are you over the **AGE** of 50 years old?	☐ YES ☐ NO	
Is your **NECK** circumference greater than 16 inches?	☐ YES ☐ NO	
Is your **GENDER** male?	☐ YES ☐ NO	
TOTAL SCORES		
Are you currently using a CPAP/BiPAP machine?	☐ YES ☐ NO	

FOR OFFICIAL USE ONLY

High risk of OSA: 5-8
Intermediate risk of OSA: 3-4
Low risk of OSA: 0-2

☐ Refer to Sleep Medicine

The Epworth Sleepiness Scale

The Epworth Sleepiness Scale is widely used in the field of sleep medicine as a subjective measure of a patient's sleepiness. The test is a list of eight situations in which you rate your tendency to become sleepy on a scale of 0, no chance of dozing, to 3, high chance of dozing. When you finish the test, add up the values of your responses. Your total score is based on a scale of 0 to 24. The scale estimates whether you are experiencing excessive sleepiness that possibly requires medical attention.

How Sleepy Are You?

How likely are you to doze off or fall asleep in the following situations? You should rate your chances of dozing off, not just feeling tired. Even if you have not done some of these things recently try to determine how they would have affected you. For each situation, decide whether or not you would have:

- No chance of dozing =0
- Slight chance of dozing =1
- Moderate chance of dozing =2
- High chance of dozing =3

Write down the number corresponding to your choice in the right hand column. Total your score below.

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

Total Score = ____________________

Analyze Your Score

Interpretation:

0-7: It is unlikely that you are abnormally sleepy.
8-9: You have an average amount of daytime sleepiness.
10-15: You may be excessively sleepy depending on the situation. You may want to consider seeking medical attention.
16-24: You are excessively sleepy and should consider seeking medical attention.

Reference: Johns MW. A new method for measuring daytime sleepiness: The Epworth Sleepiness Scale. *Sleep* 1991; 14(6):540-5.

This printed version of the Epworth Sleepiness Scale is provided courtesy of Talk About Sleep, Inc. www.talkaboutsleep.com.

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY ACT AND HIPAA RELEASE

I acknowledge that I have received the attached Privacy Notice.

____

PRINTED Patient Name

____ __________________________________

Patient or Personal Representative Signature Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

____

I, ________________________________, acknowledge that I have received a copy of the Northwest Specialty Hospital notice regarding the privacy of Personal Health Information.

In addition to our normal operational disclosures of privacy information, please identify whom we may release your health care information. Each name must be identified. These should be people who help you with your health care needs and may need to be knowledgeable about your condition, treatment, and options. It is still the responsibility of the party or parties listed below to request this information.

NAME	RELATIONSHIP

SIGNED DATE

For Facility use only:

If not signed, reason why acknowledgement was not obtained: ____

Staff Witness seeking acknowledgement

________________________________ Date: _____________________

NOTICE OF PHYSICIAN OWNERSHIP

NORTHWEST INSTITUTE FOR DIGESTIVE SURGERY

Thank you for choosing Northwest Institute of Digestive Surgery!

Northwest Institute of Digestive Surgery is owned and operated by Northwest Specialty Hospital which is a federally recognized "physician owned" specialty hospital. As a patient you have the right to receive a list of all of the physician owners in this hospital, upon request. Your physician may or may not have an ownership interest in Northwest Specialty Hospital, as not all physicians who practice here have an ownership interest. If you feel that the services that have been ordered for you are not proper or are negatively impacted by physician ownership in the facility, please notify a member of the administration immediately. Our Chief Nursing Officer can be reached by calling (208) 262-2300.

You should be aware that alternative health care facilities may be available to you.

Please sign below to acknowledge your receipt and understanding of this disclosure and that you have had an opportunity to ask and receive answers to any questions you may have about this disclosure, including your options, if any, for treatment at other facilities.

PATIENT NAME　　PATIENT SIGNATURE　　DATE

WITNESS NAME　　WITNESS SIGNATURE　　DATE

MEDICATION HISTORY CONSENT FORM

NORTHWEST INSTITUTE FOR DIGESTIVE SURGERY

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an E-Prescribe program. These include:

- **Formulary and benefit transactions** - Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form, you are agreeing that Northwest Institute for Digestive Surgery can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to enroll me in the E-Prescribe Program that allows for retrieval of my medication history. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

☐ CONSENT

PRINT SIGN DATE

PATIENT DOB PARENT OR GUARDIAN SIGNATURE DATE

☐ DO NOT CONSENT

PRINT SIGN DATE

CONSENT AND CONDITIONS OF TREATMENT

Thank you for choosing Northwest Specialty Hospital to provide for your healthcare needs. We are committed to providing exceptional healthcare. The first step in this process is to provide information regarding patient rights, risks and responsibilities. The second step is to obtain your consent to treat the patient. The admitting staff can answer any questions you may have in regards to the following agreement.

I agree to the following:

1. CONSENT TO TREAT: I consent to treatment at Northwest Institute for Digestive Surgery and for services or supplies that have been or may be ordered by a licensed professional healthcare provider. I understand that treatment may include but is not limited to: radiological examinations, laboratory procedures, anesthesia, nursing care or medical and surgical treatment. Your case may be attended by vendors and clinical students. I understand that all licensed professional healthcare providers that render service to the patient are responsible and liable for their own acts, orders and omissions. I acknowledge that the hospital has not made nor can it make a guarantee of the outcome of treatment.

2. FINANCIAL AGREEMENT: I agree to pay for all services and supplies rendered to the patient in accordance with the rates and financial policies in effect at the time of service. I authorize any overpayment made on this account to be transferred to any other account balance for which I am responsible. I agree to pay interest fees on any unpaid balance after 60 days of discharge or date of service at a rate not to exceed 18% APR. If this account is assigned to an attorney or a collection agency for collection then I agree to pay all collection agency fees, court costs, and attorney's fees.

   ☐ I am aware that financial counseling is available for any services that I may receive during my visit at Northwest Specialty Hospital.

3. ASSIGNMENT OF INSURANCE BENEFITS: I assign and authorize payment directly to Northwest Specialty Hospital of any healthcare benefits that the patient is entitled to receive. This assignment will not be withdrawn or voided at any time unless I pay the account in full. I understand that I am responsible for any and all charges not covered by my insurance policy(s). If the patient is entitled to Medicare or Medicaid benefits under Title XVIII of the Social Security Act, I request assignment of benefits directly to Northwest Specialty Hospital.

4. ASSIGNMENT OF PHYSICIAN BENEFITS: I am aware that physician services by Radiologist, Pathologist, Anesthesiologist, as well as medical, surgical and emergency care are not billed by the hospital but are billed separately. I understand that I am under the same obligation to those providers as stated in this agreement unless otherwise agreed to in writing with those providers. I authorize payment of any medical benefits for such claims to the appropriate provider.

I understand and accept the terms of this agreement and certify that I am duly authorized by the patient or by law to execute the above agreement in their behalf.

PATIENT NAME	PATIENT SIGNATURE	DATE	TIME
PATIENTS GUARDIAN OR REPRESENTATIVE	SIGNATURE	DATE	TIME
WITNESS NAME	WITNESS SIGNATURE	DATE	TIME

APPOINTMENT CANCELLATION AGREEMENT

NORTHWEST
INSTITUTE FOR DIGESTIVE SURGERY
NORTHWEST SPECIALTY HOSPITAL

Failure to keep your scheduled appointments hinders our ability to provide the best care to you. In order to restrict missed appointments, we have implemented an Appointment Cancellation Policy. We ask that in the event you need to cancel your appointment, you call at least 24 hours prior to an office visit, and 72 hours prior to surgery. This will allow us the opportunity to offer that appointment to another patient.

To cancel an appointment, please call (208) 262 0945

Repeated late cancellations and missed appointments are disruptive to the optimal delivery of care to you and our other patients. As a result, 2 late cancellations or missed appointments may result in the discontinuation of your care at NWIDS. In the event you are discharged from care, your referring provider or case manager will be notified of the reason for discharge from our practice.

Fees:

At NWIDS, failure to give 24 or 72 hours notice prior to cancellation will result in an "Appointment No Show Fee". This fee cannot be billed to your insurance and will be your direct responsibility.

The No Show Appointment Fees are as follows:

Office Visit Appointment: $50

Endoscopy/Surgery Appointment: $100

I understand that NWIDS's appointment cancellation policy and understand my responsibility to plan appointments accordingly. I also agree to notify NWIDS appropriately if I have difficulty fulfilling my scheduled appointments.

____

Patient Name (Print)

____ ________________________________

Patient Signature Date