Deaconess
WEIGHT LOSS
SOLUTIONS

Thank you for your interest in our programs. You are taking a step towards better health.

This packet contains information about our nonsurgical weight loss program, Healthy Eating and Living Program (HELP), and our Pre-Bariatric Surgery Program. We provide flexibility between the 2 programs, dependent on insurance coverage, because we understand that weight loss is a journey and want to provide the path that fits your lifestyle best. Our mission is to provide support and education for the lifelong journey that is weight loss and weight maintenance.

The **Healthy Eating and Living Program (HELP)** provides numerous visit options which we tailor to the individual needs of our patients. Visits include time with the medical provider, dietitian and exercise specialist. The program includes nutrition classes which can be completed online or zoom meetings, logging food, and physical activity. We may also recommend medical testing (i.e. labs or sleep study).

The **Pre-Bariatric Surgery Program** is a 6-9 months or more program; however, insurance may require additional monthly visits or it may take longer if medical clearance has not been obtained in order to move forward with seeking surgery approval (Gastric Bypass or Vertical Sleeve Gastrectomy). This program requires monthly visits with the medical provider, dietitian and exercise specialist. During this part of the program, we will require you to log food and exercise, complete a series of nutrition classes, attend a group support meeting, complete a psychological evaluation and undergo medical clearance for bariatric surgery, which may require referrals to specialists dependent on your medical conditions.

If you are interested in the surgical program, we require that you complete the online new patient seminar prior to being scheduled for your new patient appointment. This is located on our website at deaconess.com/weightloss. Please make sure to answer the five questions after the seminar is over.

Prior to your first appointment, the following step must be completed:

1. We ask that you complete all new patient paperwork for the bariatric providers to review. Once the paperwork is completed, return it to our office by fax to 812-858-6843 or mail to 4219 Gateway Blvd., Ste. 2001, Newburgh, IN 47630. Once your medical information is reviewed by our provider, we will call to schedule your initial consultation.

2. Prior to us scheduling your new patient appointment our provider will review your paperwork as well as your insurance information will be submitted to the hospital verification department. They will confirm your insurance requirements and benefits to determine if your plan has bariatric coverage. Once this has been done and you have completed the Online New Patient Seminar we will schedule your initial appointment. Should you desire to know your bariatric benefits prior to your first visit, you can contact your insurance company.

Once the above steps have been completed, we will contact you and review your insurance coverage and schedule your initial appointment. The first appointment may last up to 3 hours. The provider will do the initial exam, take a comprehensive history, provide an overview of the program, and make a recommendation. The exercise specialist will do an In-Body exam, and go over exercise options. The dietitian will review the program requirements, such as keeping food logs and taking nutrition classes.

You are worth the time and dedication to this program and our team is here to support you every step of the way.

Please feel free to contact our office if you have any questions about our programs. We look forward to helping you reach success with your health goals.

4219 Gateway Blvd., Ste. 2001, Newburgh IN 47630 | deaconess.com/weightloss | Phone: 812-450-7419 | Fax: 812-858-6843

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Welcome to Deaconess Weight Loss Solutions,

During each of your visits you will be seen by a clinic provider, exercise specialist and one of our dietitians. Please review the **important patient notification below:**

- Weight Loss Solutions is an outpatient department of Deaconess Hospital. As such, your insurance company will be billed:
  1. A facility fee for the services
  2. A nutrition charge for the dietitian's services
  3. A professional fee for services provided by our provider

If you are participating in our surgical program, prior to your surgery, you will see one of our surgeons here in our office. You will be seen again by the whole team. Please review the **important patient notification below:**

- Your insurance company will be billed:
  1. A facility fee for the services
  2. A nutrition charge for the dietitian's services
  3. A professional fee from Evansville Surgical Associates for services provided in our office by one of the surgeons, Dr. Todd Burry or Dr. Jay Woodland.

Thank you for allowing us to take care of you. We will make every attempt to honor appointment times. Unavoidable delays may occur at times. We welcome your feedback in helping us provide quality care to you. Please complete the Patient Satisfaction Survey that you will get by email, phone call or text. If you have any questions or concerns about the information, please call our office and we will be happy to assist you.

Sincerely,
Deaconess Weight Loss Solutions Staff

My signature below indicates I have read and understand the information above.

Patient Signature _____ Date _____

PATIENT INFORMATION

Patient Name: _____

Street Address: _____

Mailing Address: _____

Phone Numbers: _____

Date of Birth: _____ Social Security #: _____

Email:_____

Sex: ❑ Male ❑ Female ❑ Other_____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Employer:_____ Employer Phone:_____

Employer Address: _____

Spouse Name:_____ Spouse Phone: _____

Spouse Date of Birth:_____ Spouse Social Security #: _____

Spouse Employer:_____

Emergency Contact:_____ Phone Number: _____

INSURANCE INFORMATION

Primary Insurance Company Name: _____

Claim Address: _____

Phone Number (Customer Service or Precertification Number):
Member ID:
Group Number:
Primary Policyholder:
Relationship to Patient:
Policyholder Date of Birth:
Policyholder Social Security #:
Employer, if through employment:

Secondary Insurance Company Name: _____

Claim Address: _____

Phone Number (Customer Service or Precertification Number):
Member ID:
Group Number:
Primary Policyholder:
Relationship to Patient:
Policyholder Date of Birth:
Policyholder Social Security #:
Employer, if through employment:

Tertiary Insurance Company Name:_____

Claim Address: _____

Phone Number (Customer Service or Precertification Number):
Member ID:
Group Number:
Primary Policyholder:
Relationship to Patient:
Policyholder Date of Birth:
Policyholder Social Security #:
Employer, if through employment:

Please provide a copy of your insurance card(s), front and back, via fax, email or mail, along with the completion of the insurance information above.

MEDICAL HISTORY

Patient Name:_____Date of Birth: _____

Who is Your Primary Care Provider (PCP): _____

PCP Address:_____ PCP Phone: _____

Have you ever had a bariatric surgery or procedure?: ❑ Yes ❑ No

If yes, what kind?: ❑ Lap Band ❑ Sleeve ❑ Nissen ❑ Gastric Balloon ❑ Gastric Bypass

When was the Surgery?:_____

Where did You have the Surgery?:_____

Height:_____ Weight:_____ BMI:_____

Medical Condition your are **CURRENTLY** being treated:		
Condition:		Year Diagnosed:
❑	Acid Reflux (GERD)	
❑	Anxiety	
❑	Arthritis	
❑	Asthma	
❑	Back Pain	
❑	Bipolar Disorder	
❑	Cancer	
❑	Crohn's Disease	
❑	Ulcerative Colitis	
❑	COPD	
❑	Depression	
❑	Diabetes	
❑	Heart Attack	
❑	Heart Disease	
❑	High Blood Pressure	
❑	High Cholesterol	
❑	Joint Pain	
❑	Thyroid Cancer	
❑	Sleep Apnea ❑ C-Pap ❑ Bi-Pap	

Medications (Name/Dose/Frequency)

Medication Allergies	
Medicine	Reaction

Are you currently on dialysis?	❑ Yes	❑ No
Are you on a transplant list?	❑ Yes	❑ No
Do you have a single kidney?	❑ Yes	❑ No
Are you wheelchair bound?	❑ Yes	❑ No
Do you currently use oxygen?	❑ Yes	❑ No

Ever been treated for binge eating?	❑ Yes	❑ No
Ever had surgery outside of the USA?	❑ Yes	❑ No
Do you have a family history of thyroid cancer?	❑ Yes	❑ No
Ever had Pancreatitis?	❑ Yes	❑ No
Ever been diagnosed with MEN?	❑ Yes	❑ No

SOCIAL HISTORY

Do you drink alcohol? ❑ Yes ❑ No

If yes, how often do you drink? _____

If yes, how many drinks/day? _____

Did you drink heavily in the past? ❑ Yes ❑ No

If yes, do you still? _____

If you stopped drinking, when did you stop?_____

Do you currently use illegal drugs? ❑ Yes ❑ No

Have you used drugs in the past? ❑ Yes ❑ No

When did you start using? _____

When did you stop using?_____

What drugs/substances do you use?

_____

_____

Do you currently smoke? ❑ Yes ❑ No

If yes, how many packs/day?_____

When did you start smoking? _____

Are you willing to quit? ❑ Yes ❑ No

Did you previously smoke? ❑ Yes ❑ No

When did you quit?_____

Did you use e-cigarettes? ❑ Yes ❑ No

Do you exercise? ❑ Yes ❑ No

How frequently?_____

SURGICAL AND HOSPITALIZATION HISTORY

Dates Type of Surgery or Reason for Hospitalization

_____

_____

_____

_____

_____

_____

_____

_____

FAMILY HISTORY

If you are unaware of your family history, please document here:_____

Relative	Arthritis	Cancer	Diabetes	Heart Attack	Heart Disease	High Blood Pressure	Liver Disease	Lung Disease	Obesity	Sleep Apnea	Stroke	Age/Cause of Death
Mother												
Father												
Maternal Grandmother												
Maternal Grandfather												
Paternal Grandmother												
Paternal Grandfather												
Sibling 1												
Sibling 2												
Sibling 3												
Sibling 4												

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EPWORTH SLEEPINESS SCALE

Patient Name: _____

Today's Date:_____ Patient's Age:_____

Sex: ❑ Male ❑ Female ❑ Other_____

How likely are you to doze off or fall asleep in the situations described below, in contrast to just feeling tired? **This refers to your usual way of life in recent times.**

Even if you have done some of these things recently, please try to indicate how they **might** have affected you. Use the following scale to choose the **most appropriate number** for each situation:

0 = You would **never** doze off.
1 = There is a **slight** chance of your dozing off.
2 = There is a **moderate** chance of you dozing off.
3 = There is a **high** chance of you dozing off.

Situation	**Chance of You Dozing Off**
Sitting and reading	_____
Watching TV	_____
Sitting inactive, in a public place (such as a theatre, a meeting, etc.)	_____
As a passenger in a car for one 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	_____
YOUR TOTAL:	_____

Score:

0 to 10 Normal Range | 10 to 12 Borderline | 12 to 24 Abnormal Range

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Name _____ CSN (office use only) _____

Date of Birth _____ MRN (office use only) _____

NUTRITION ASSESSMENT QUESTIONNAIRE

Welcome to Deaconess Weight Loss Solutions. We look forward to supporting you in your journey to better health through weight loss. Please answer all of the following questions. If a question does not apply to you, answer with N/A.

GENERAL INFORMATION

Why are you seeking a weight loss program? How do you see this benefiting you?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

METHOD

Please put a check mark by your preferred method of weight loss.

☐ Gastric Bypass
☐ Sleeve Gastrectomy
☐ Non-Surgical Healthy Eating and Living Program

SPECIAL DIETS

Are you currently on a special diet? ☐ YES ☐ NO

If yes, who prescribed it? _____

What is your currently prescribed diet

☐ Low fat ☐ Low Salt
☐ Carbohydrate Controlled
☐ Other _____

FOOD ALLERGIES

Please list any food allergies or intolerances: (e.g., lactose intolerance, shellfish, gluten, etc.)

_____

_____

_____

_____

EATING ISSUES

☐ **YES** ☐ **NO** Wake up in the middle of the night and eat

☐ **YES** ☐ **NO** Wake up in the morning to find evidence that you have eaten, but you don't remember the episode

☐ **YES** ☐ **NO** Frequently skip meals

☐ **YES** ☐ **NO** Frequently crave sweets during the day

☐ **YES** ☐ **NO** Frequently fast as a part of your diet plan

☐ **YES** ☐ **NO** Are you a vegetarian (check one):
☐ Vegan ☐ Vegetarian
☐ Octo-lacto ☐ Octo ☐ Lacto

☐ **YES** ☐ **NO** Drink alcoholic beverages (If yes, how often do you drink?)
_____

☐ **YES** ☐ **NO** Feel that there are foods that you cannot live without

☐ **YES** ☐ **NO** Experience problems with chewing or swallowing

If you checked yes on any of the above, please explain:

_____

_____

_____

_____

ENVIRONMENTAL ISSUES THAT AFFECT YOUR WEIGHT

☐ **YES** ☐ **NO** Occupational (working around food/no time for lunch)
☐ **YES** ☐ **NO** Sleep
☐ **YES** ☐ **NO** Travel
☐ **YES** ☐ **NO** Household (family/obligations/schedule)
☐ **YES** ☐ **NO** Shopping or cooking
☐ **YES** ☐ **NO** Meals eaten away from home

If you checked yes on any of the above, please explain:

PLEASE CHECK ALL THAT APPLY

I get my groceries at:

☐ Grocery Store
☐ Convenience Store
☐ Food Stamps
☐ Food Banks
☐ Farmer Market
☐ Other

☐ **YES** ☐ **NO** Do you have any issues purchasing nutritious foods?

☐ **YES** ☐ **NO** Do you have access to a kitchen?

If you DO NOT have a good food supply for the month, how long does your food supply last?

☐ 3 weeks ☐ 2 weeks ☐ 1 week

If you do not have an adequate food supply for the entire month, what do you do?

ADDITIONAL QUESTIONS

How long have you been overweight or obese?

Were you overweight as a child?

How much weight do you want to lose?

Who does the grocery shopping?

Who prepares the meals in your home?

On average how many non-starchy vegetables do you eat daily?

On average how many fruits do you eat daily?

SUPPORT STRUCTURE

List the people who will be there to support you during your weight loss journey.

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HEALTHY EATING AND LIVING PROGRAM REQUIREMENTS

Please read the non-surgical program requirements, initial each box and submit a signed copy with your New Patient Packet documents.

- ❑ 1. Meeting with the Registered Dietitian and Exercise Specialist along with your provider is a requirement of this program. You may have some follow ups with only the Registered Dietitian and Exercise Specialist throughout the program. If your insurance does not cover nutrition visits, you will be responsible for the remaining balance. *If you have Medicare or a Medicare-based insurance your nutrition visits may be a non-covered service.*
- ❑ 2. Food and exercise logs are required for the program. Please bring logs monthly to each nutrition visit (with the exception of initial visit). If no logs are submitted within the first 60 days of your initial visit you may be deemed as non-compliant and may be terminated from the program.
- ❑ 3. Must be drug-free 6 months prior to starting the program and remain drug-free for the entire length of the program.
- ❑ 4. Patient cannot have an uncontrolled psychiatric disease or a recent psychiatric hospitalization within the past 6 months.
- ❑ 5. Appointment time slots are in high demand. If you are an established patient, this may result in termination from the program after the second no-show.
- ❑ 6. Nutrition classes are required and each patient will need to complete at least 6 classes. These classes can be done online. More information will be given at your first visit.
- ❑ 7. Bariatric Support Group is required and each patient must complete at least 1 throughout the program.
- ❑ 8. If your insurance company approves of bariatric services, please keep in mind that some services may not be covered; please financially plan to have funds available to cover routine items such as labs, Opti-fast meal replacement, and the ability to provide meals from all food groups.
- ❑ 9. Some patients may need additional testing such as chest x-ray, EKG, and/or sleep study, and additional labs. Please know this is a part of your weight loss journey and highly recommended to uncover any additional medical issues. Some of the tests may be out-of-pocket expenses if not covered by your insurance. If any abnormalities are founding during the medical clearance testing, additional workup may be required.

I acknowledge I have read and understand the information above, and my signature states I will comply with the program requirements. Failure to comply with program requirements may result in dismissal from the program.

Signature _____ *Date* _____

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SURGICAL PROGRAM REQUIREMENTS

Please read the Surgical Program Requirements initial each box and submit a signed copy with your New Patient Packet documents.

❑ 1. Minimum of 6 consecutive clinic visits required unless insurance specifies more and a Psychological Evaluation (This also includes self-pay patients.) Please keep in mind that it can take longer as things may come up that need further workup. In addition, some insurance plans require additional months or consecutive months. Some insurance companies may require you to start over if you miss a month. Once you have completed all insurance requirements we will submit your information to your insurance company for approval which could take up to 30 days, but the process may take longer pending the insurance. Along with insurance approval you will have to be medically approved to move forward by our provider prior to being scheduled with the surgeon. Please note there is no guarantee when you will have surgery as it will depend on you, your health, and the surgeon's schedule.

❑ 2. Minimum of 6 consecutive nutrition visits with Registered Dietitian and Exercise Specialist. If your insurance does not cover nutrition visits, you will be responsible for remaining balance. Meeting with the Registered Dietitian and Exercise Specialist along with our provider is a requirement of each monthly visit – please plan accordingly.
If you have Medicare or a Medicare - based insurance your nutrition visits may be a non-covered service.

❑ 3. Minimum of 6 consecutive months' worth of food and exercise log unless insurance specifies more are required for the program. Please bring logs monthly to each nutrition visit (with the exception of initial visit). If no logs are submitted within the first 60 days of your initial visit you may be deemed as non-compliant and may be termed from the program.

❑ 4. Must be drug-free for 1 year prior to starting program and remain drug-free for the entire length of program.

❑ 5. Must pass a nicotine screening 6 weeks prior to surgery approval and must remain nicotine free for surgery.

❑ 6. Patients cannot have an uncontrolled psychiatric disease or a recent psychiatric hospitalization within the last year.

❑ 7. Appointment time slots are in high demand; please call the office at least 24 hours in advance if you cannot keep your appointment. If you fail to come for your new patient appointment; you will be required to wait a full 6 months to restart. If you are an established patient this may result in termination from the program after 2nd no-show within 1 year.

SURGICAL PROGRAM REQUIREMENTS, CONTINUED—

- ❑ 8. Nutrition Classes are required and each patient will need to complete 6 prior to surgery. These classes must be complete prior to obtaining insurance approval. These classes can be done online or via zoom. More information will be given at your first visits.
- ❑ 9. Bariatric Support Group is required and each patient must complete at least 1 prior to surgical clearance.
- ❑ 10. If your insurance company approves of bariatric services, please keep in mind that some services may not be covered; please financially plan to have funds available to cover routine items such as labs, EGD, vitamins, Optifast, and ability to provide meals from all food groups.
- ❑ 11. A psychological evaluation is required for the surgical program. If your insurance does not cover this service please be prepared to pay approximately $475 out of pocket to cover evaluation expenses. If you chose to have your evaluation performed at a facility outside of our standard facilities, it is the patient's responsibility to provide all necessary psych evaluation requirements to this facility and ensure information is returned back to Deaconess Weight Loss in a timely manner. Outside facilities may delay the process in your program.
- ❑ 12. Some patients may need additional testing such as Chest X-Ray, EKG, and/or Sleep Study, and additional labs please know this is a part of your weight loss journey and highly recommended to uncover any additional medical issues. Some of the tests may be out – of -pocket expenses if not covered by your insurance. If any abnormalities are founding during the medical clearance testing, additional workup may be required.

Please note: Your initial appointment with the surgeon may last 4 -5 hours, your second appointment with the surgeon and all post op appointments may last up to 2 -3 hours. During each visit with our office you will see the provider, dietitian, and exercise specialist; so please plan your schedule accordingly. Pre-testing labs and an EGD will be scheduled to be done during your first surgeon visit; usually 2 – 3 weeks later. Once you have completed the EGD the surgeon will let us know if we can move forward with scheduling your bariatric surgery. Once your surgery date is obtained, we will schedule you to see the surgeon again prior to surgery; you may also require additional pre-testing at that time. Please keep in mind any out-of-pocket expense due by your insurance company must be paid prior to your bariatric surgery since this is considered an elective surgery. If at any time the surgeon or our provider feels you need additional testing or if you are not a good candidate for surgery with our office, you will be notified of this as soon as possible.

I acknowledge I have read and understand the information above, and my signature states I will comply with the program requirements. Failure to comply with program requirements may result in dismissal from the Deaconess Weight Loss program.

Signature _____ Date _____

Deaconess Clinic

PERMISSION TO DISCUSS MY CARE

Patient name	Birthdate

I permit the following information to be discussed with those of my family, friends or others listed below. I understand that if I want any of these persons to receive a copy of my records, I must complete and sign a separate 'Authorization' or 'Release of Information' form. Copies of my complete record can be obtained through the Medical Records Department. Copies of individual test results or office notes can be obtained from the physician office.

❑ Appts only
❑ Results/Plan of care _____ _____ _____
❑ My bill Name Relationship Phone

❑ Appts only
❑ Results/Plan of care _____ _____ _____
❑ My bill Name Relationship Phone

❑ Appts only
❑ Results/Plan of care _____ _____ _____
❑ My bill Name Relationship Phone

❑ Appts only
❑ Results/Plan of care _____ _____ _____
❑ My bill Name Relationship Phone

Discussion of results or plan of care will not include mental health counseling sessions, for which a separate form is required.

In an emergency or if admitted to the hospital and unable to make my wishes known, I understand that my doctor and hospital staff may rely on the above permission to determine with whom they may discuss my care.

The above permissions can be changed by me at any time by notifying my doctor's office, Medical Records or the Deaconess Health System Privacy Officer.

_____ _____
Patient signature Date

_____
Printed name

_____ _____
Signature of lawful personal representative * Telephone

_____
Printed name

*Required only if patient is a minor or unable to represent self