Thank you for your interest in being seen as a patient at The UT Health East Texas Bariatric Center. Please review all of the enclosed information, including the Notice of Privacy Practices (HIPAA)

Please complete all of the forms to the best of your knowledge. There are several places to sign where indicated. If there are any forms that you are not comfortable signing until you have had a chance to ask any questions about them, that is OK.

What We Offer

Surgeries: Laparoscopic Gastric Bypass Laparoscopic Sleeve Gastrectomy, Lap-Band, Switch (SADI-S and Classic Switch/DS), Revisions.

Experience and Specialization: 18 years and over 7000 patients. Bariatric surgery ***is what we do.***

Pre-operative Weight Management Program.

Support groups and post-operative nutrition classes.

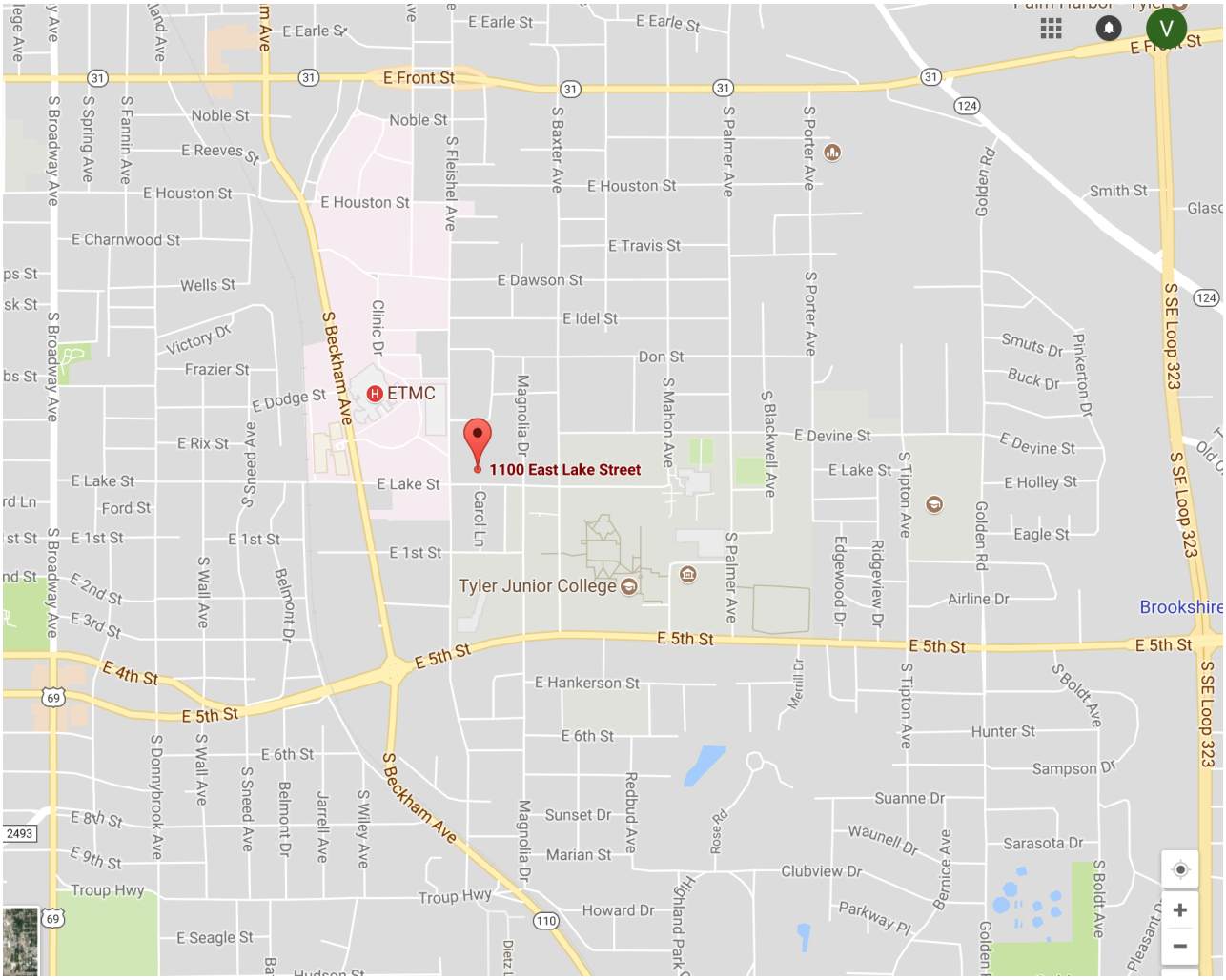
Accredited facilities: Tyler is the tertiary referral center for East Texas, with the full range of specialists, advanced facilities and technology. Surgeries are performed at UTHealth East Texas (formerly East Texas Medical Center) an accredited center for bariatric surgery by the ACS/ASMBS Quality Improvement Program

Instructions For Your First Visit

Scheduled for: _____

1. Please prepare to spend 4-5 hours with us. The visit will include an orientation, diet instructions, introduction and talks from staff, a small group seminar with our team, and an individual one-on-one consultation with Dr. Babineau or Dr. Keith. **We encourage you to bring your spouse or other support person with you. Please do not bring babies or young children**.
2. **Please complete and sign the enclosed forms to the best of your ability**.
3. Contact your insurance company to see if they have benefits for bariatric surgery. Call the customer service number on your ID card, and be persistent! Find out what they require to approve surgery, and start gathering any supporting documents and records. This will speed up the insurance approval process
4. Bring your insurance ID card, completed forms, and records to the appointment. **We look forward to meeting you!**

Map and Directions



We are located at 1100 East Lake Street, Tyler, TX 75701. It is a 3 story dark red brick office building at the corner of East Lake and Fleishel

Coming from the North/West

Take I-20 to EXIT 556 US-69 Lindale/Tyler. Go SOUTH on US-69. Continue on US-69 S across loop 323 where it becomes E Gentry Pkwy. Turn RIGHT onto N Beckham Ave/US-271 S/TX-155. Continue to follow N Beckham Ave/TX-155. Turn LEFT onto E Lake Sleeve which is just past Hospital Dr. (If you reach E 1st street you have gone about 0.1 miles too far.)Go through the light for E. Lake and Fleishel and 1100 E LAKE is on the left.

Coming from the South

Go NORTH on US-69 to Tyler. Take a RIGHT on Loop 323. Turn LEFT on Troup HWY/TX-110 Stay on Troup HWY (will change name to Beckham after you cross Railroad Tracks). After RR tracks, take RIGHT on Lake Street. You will pass McDonalds on the right - it is the next street. Go through the light for E. Lake and Fleishel and 1100 E LAKE is on the left.

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully**

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used.

"HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your medical records only for each of the following purposes: **treatment, payment, and health care operations**.

Treatment means providing, coordination, or managing health care and related services by one or more health care providers. An example of this would include an office examination.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example would be an internal quality assessment review.

We may also create and distribute unidentified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the attention of the Privacy Officer:

1) The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do not agree to the restriction, we must abide by it unless you agree in writing to remove it.
2) The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
3) The right to inspect and copy your protected health information.
4) The right to amend your protected health information.
5) The right to receive an accounting of disclosures of protected health information.
6) The right to obtain a paper copy of the Notices of Privacy Practices form upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003, and we are required to abide by the terms of the Notices of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or the Department of Health & Human Services, Office of Civil Rights about violations of the provisions of this notice or the policies and procedures of our office.

We will not retaliate against you for filing a complaint.

Please contact us for more information:

UT Health East Texas Bariatric Center
1100 East Lake St., Ste. 150
Tyler, Texas 75701
(903) 593-0230

U.S. Department of Health & Human Svcs.
Office of Civil Rights
1301 Young Street, Ste. 1169
Dallas, Texas 75202
(214) 767-4056
(877) 696-6775 - Toll Free

DEFINITIONS

HIPAA: Health **I**nsurance **P**ortability and **A**ccountability **A**ct of 1996

A federal law that requires the use of national identification systems for healthcare patients, providers, payers (or insurance plans), and employers or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable healthcare information.

PHI: Protected **H**ealthcare **I**nformation

Individually identifiable health information (IIHI) held or disclosed by a physician's office regardless of how it is communicated (e.g., electronically, verbally or written).

IIHI: Individually **I**dentifi able **H**ealth **I**nformation

Any health information (including demographics/addresses, etc) that is collected from the patient or created or received by a healthcare provider or other covered entity or employer that relates to the past, present or future physical or mental health or condition of an individual OR the provision of healthcare or the past, present or future payment for the provision of healthcare at your physician's office AND that could potentially identify an individual. (e.g. Name/address/birth date/phone number, etc.)

Healthcare

Healthcare includes, but is not limited to preventive, diagnostic, therapeutic, rehabilitative maintenance, or palliative care, and counseling service, assessment, or procedure with respect to the physical or mental condition, or functional status of an individual or that affects the structure or function of the body; and sale or dispensing of a drug, device, equipment or other item in accordance with a prescription.

Healthcare Operations

Activities related to business, clinical management and administrative duties. Some examples of these activities are the use of **PHI (**Personal Health Information) to obtain a referral, quality assurance, quality improvement, case management, training programs, licensing, credentialing, certification, accreditation, compliance programs, business management and general administrative duties of the physician's office.

TPO: Treatment, **P**ayment, Healthcare **O**perations

We as the physician's office can disclose protected healthcare information needed to conduct daily business.

HIPAA: Patient Consent For Use and Disclosure of Protected Health Information

With my consent, Dr. Hugh Babineau, Dr. Charles Keith, and UT Health East Texas may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to the Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Hugh Babineau, Dr. Charles Keith, and UT Health East Texas reserve the right its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices May be obtained by forwarding a written request to UT Health East Texas, at 1100 East Lake St, Suite 150, Tyler Texas 75701.

With my consent, Dr. Hugh Babineau, Dr. Charles Keith, and UT Health East Texas or staff may *make calls* to my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With my consent, Dr. Hugh Babineau, Dr. Charles Keith, and UT Health East Texas or staff may *send mail* to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and insurance statements as long as they are marked Personal and Confidential.

With my consent, the Dr. Hugh Babineau, Dr. Charles Keith, and UT Health East Texas or staff may *e-mail* to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders and insurance statements.

I have the right to request that Dr. Hugh Babineau, Dr. Charles Keith, and UT Health East Texas restric how they use or disclose my PHI to carry out TPO, However, the practice is not required to agree to my requested restrictions, but if it does, is bound by the agreement.

By signing this form, I am consenting to Dr. Hugh Babineau, Dr. Charles Keith, and UT Health East Texas to use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Dr. Babineau, Dr, Keith and/or the other providers at UT Health East Texas may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Patient's Name (printed) Legal Guardian's Name

Statement of Financial Responsibility

Hugh P. Babineau, MD, Charles J, Keith, MD and the other providers at UT Health East Texas are in private practice and bill independently from the hospital for all services, such as office visits and surgery. (Routine postop visits are included in the surgery fee, up to 90 days from the surgery). If you have health insurance, our office will file claims in accordance with usual practices. We cannot, however, verify insurance benefits for all patients in advance of their office visit.

Co-pays and deductibles: All or part of provider services are sometimes denied payment by insurance companies. Examples of reasons include: the provider is out of network, certain services are not eligible, you have been dropped by the plan, the plan has been cancelled by the employer, your plan does not cover certain diagnoses such as obesity or morbid obesity. Even if your surgery and office visits are approved by insurance, most insurance plans have a co-pay or deductible that the patient is required to pay to the physician, hospital or other provider of care. Any amount of our fees that the insurance does not pay, (up to the amount allowed by the insurance contract if one of our providers is a participating provider) is the patient's responsibility.

Participation in insurance plans or networks: Our providers participate in numerous insurance plans. This means that he we are "in-network provider" for many plans, such as BlueCross BlueShield and United Healthcare, but may be "out-of-network" for others. If we are "out-of-network," most plans will allow you to use us for your surgery and other care, but we are not obligated to accept as full payment what the plan pays. In other words, you will probably have a larger out-of-pocket payment if our providers do your surgery and is out-of-network.

Other providers to whom you will be financially responsible include: assistant surgeon, hospital, and anesthesiologist. In addition, you may be billed by other providers such as a radiologist, pathologist or other physicians asked to take part in your care.

Although we will file claims with your insurance, you are ultimately responsible for all fees for services rendered by Dr. Babineau, Dr. Keith, UT Health East Texas *and all of the other providers involved in your care*.

By signing below, you are indicating that you have read and understood all of the above information. You are also agreeing to pay for any and all services rendered by Dr. Hugh P. Babineau, MD and other providers involved in your care.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Patient's Name (printed) Legal Guardian's Name

Patient Information Sheet

Last Name _____First _____MI_____

Date of Birth _____SS# _____Sex ____

Race _____Gender _____Marital Status _____

Home Address_____

City _____State_____Zip _____

Home Phone_____Work Phone_____Mobile _____

Employer _____

Employer's Address_____

Primary Insurance Holder Information ☐ **Same as above**

Last Name _____First _____MI_____

Date of Birth _____SS# _____Sex ____

Home Address_____

City _____State_____Zip _____

Home Phone_____Work Phone_____Mobile _____

Employer _____

Employer's Address_____

Emergency contact and phone# _____

Primary Physician and phone# _____

Pharmacy and phone# _____

Primary Insurance _____

Secondary Insurance_____

ASSIGNMENT OF INSURANCE BENEFITS

Patient's Name_____

I authorize **Dr. Hugh Babineau, Dr. Charles Keith, and UT Health East Texas** to submit claims to my insurance carrier for benefits for myself, my spouse, or dependent and receive payment for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted. I agreed that I will be bound by this signature as though I had personally signed the claim form. I hereby assign directly to **Dr. Hugh Babineau, Dr. Charles Keith, and UT Health East Texas** all insurance benefits otherwise payable to me for his services. I authorize any insurance company of mine to pay **Dr. Hugh Babineau, Dr. Charles Keith, and UT Health East Texas** directly for any bill incurred by me, my spouse, or dependent.

_____ _____

Signature of Insured Date

MEDICARE AUTHORIZATION

Patient's Medicare Number_____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Dr. Hugh Babineau, Dr. Charles Keith, and UT Health East Texas** for any services provided to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claims. If "other health insurance " is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing information to the insurer or agency shown. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Beneficiary Signature Date

RELEASE OF INFORMATION

I hereby authorize **Dr. Hugh Babineau, Dr. Charles Keith, and UT Health East Texas** to send a copy of my medical records to my referring physicians and my insurance companies. I hereby authorize the release of any information relating to all insurance claims for benefits submitted on my behalf.

I understand that this authorization in no way releases me from primary responsibility for the payment of my bill and I understand that I am financially responsible for all charges incurred whether or not paid by my insurance.

_____ _____

Signature of Patient (or Parent if minor) Date

Office Visit Cancellation Policy and Late Policy

- We see patients by appointment only.
- We ask that you cancel appointments as soon as you know you can't make it.
- Late or missed appointment fee and policy:

  If you do not cancel within 24 hours or are more than 15 minutes late, this is considered a missed appointment and we will charge a $25 late cancellation fee. The fee is not filed on insurance and will be required to be paid prior to scheduling the next appointment.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Patient's Name (printed) Legal Guardian's Name

Authorization to Disclose Medical Information

Statement of Intent

It is my understanding that due to a law entitled the Health Insurance Portability and Accountability Act of 1996 (“HIPPA”), that there are federal regulations that interpret and implement that law, and that HIPPA limits disclosure of my “Individually Identifiable Health Information” to certain of my family and friends whom I may designate, regardless of my state of health. I am signing this authorization so that my Health Care Providers **can disclose my health care information to the persons listed below, and openly discuss that information with them**.

Authorization

I, _____, hereby authorize the Dr. Hugh Babineau, Dr. Charles Keith, and UT Health East Texas, to fully disclose my Individually Identifiable Health Information to the following individuals (my “**Personal Representatives**”):

Name: _____

Date of Birth: _____

Address: _____

_____

Phone: _____

Name: _____

Date of Birth: _____

Address: _____

_____

Phone: _____

Name: _____

Date of Birth: _____

Address: _____

_____

Phone: _____

_____ _____

Signature of Patient or Legal Guardian Date

Name _____

Who is your primary physician?_____

How were you referred to us? _____

Obesity History

How long have you been overweight? _____

What is the most you have ever weighed, and when? _____

Please list any diets, medications or other weights loss attempts. Give dates, if you can:

_____

_____

_____

_____

_____

Medical and Surgical History

Do you have **hypertension** (high blood pressure)? .....❒Yes ❒No

If "yes", how many medications do you take for hypertension? .....

Do you have **congestive heart failure** (CHF)? .....❒Yes ❒No

Do you have **coronary artery disease** or any other heart problems? .....❒Yes ❒No

If "yes" to heart disease, describe _____

Do you have **angina** or chest pains?.....❒Yes ❒No

Do you have any **vascular disease** (blockages in arteries other than heart)? .....❒Yes ❒No

If "yes" to vascular disease, describe _____

Do you have **fluid retention** (edema) in your feet, ankles or legs?.....❒Yes ❒No

Have you had a **Deep Venous Thrombosis** (DVT) or Pulmonary Embolus(PE)? .....❒Yes ❒No

If "yes" to DVT or PE, describe _____

Do you have **Diabetes**?.....❒Yes ❒No

If "yes" to diabetes, when was it diagnosed?_____

If "yes" to diabetes, do you take insulin, oral meds or no meds? _____

Do you have **high cholesterol** or high lipids?.....❒Yes ❒No

Do you take medications for **high cholesterol or high lipids?**.....❒Yes ❒No

Have you had any problems with **gout**?.....❒Yes ❒No

Do you have **Sleep Apnea**? (Stop breathing at night)? .....❒ Don't know ❒Yes ❒No

If "yes" to Sleep Apnea, has it been diagnosed by a physician or sleep test?.....❒Yes ❒No

Do you use a breathing machine at night (CPAP or BiPAP) for sleep apnea? .....❒Yes ❒No

Do you have **asthma** or any other breathing problems? .....❒Yes ❒No

If "yes," describe _____

Do you have **GERD** (acid reflux)? .....❒Yes ❒No

How often do you have GERD symptoms? .....

List any medications you take for GERD .....

Have you had gallstones or **gallbladder problems**? .....❒ Don't know ❒Yes ❒No

If "yes", give details:.....

Have you had any **liver disease** or problems? .....❒Yes ❒No

If "yes", give details:.....

Do you have **back pain**? .....❒Yes ❒No

If "yes," give details:.....

Do you have **fibromyalgia**?.....❒Yes ❒No

Have you been diagnosed with **arthritis** in any joints? .....❒Yes ❒No

Have you had any joints replaced?.....❒Yes ❒No

Do you have joint pains that have no been diagnosed as arthritis? .....❒Yes ❒No

Please give details on joint pains and arthritis (which joints, etc.) .....

.....

Do you have **Polycystic Ovarian Syndrome** (PCOS)?.....❒ Don't know ❒Yes ❒No

Do you have any other menstrual (female) problems such as heavy bleeding? .....❒Yes ❒No

If yes, describe.....

Do you have **Depression**? .....❒Yes ❒No

If yes, how is it treated? .....

Have you ever been hospitalized for Depression? .....❒Yes ❒No

Have you been diagnosed with **any other mental health conditions** , such as Bipolar Disorder, Panic Disorder, Generalized Anxiety, Psychosis, or Personality Disorder? .....❒Yes ❒No

If "yes," please describe.....

Do you smoke or use smokeless tobacco? .....❒Yes ❒No

If "yes" to tobacco, describe (packs per day, etc) .....

Do you drink any alcohol? .....❒Yes ❒No

If "yes" to alcohol, how much, how often? .....

Do you use any "recreational" or illegal drugs? .....❒Yes ❒No

Do you have any **urinary incontinence** (leakage of urine)? .....❒Yes ❒No

If "yes", how often? .....

Do you have **Pseudotumor Cerebri**? .....❒ Don't know ❒Yes ❒No

Do you have a **hiatal hernia**? .....❒ Don't know ❒Yes ❒No

Do you have an abdominal **hernia** or problems with your abdominal skin?.....❒Yes ❒No

If yes, describe.....

Check any others that apply and include date of onset and any other comments:

❒ Infertility_____

❒ Kidney Problem_____

❒ Stroke _____

❒ Cancer _____

❒ Epilepsy / Seizures _____

List all surgeries:

_____ _____

_____ _____

_____ _____

Please list any other hospitalizations, diseases, conditions:

_____

_____

_____

_____

_____

_____

List all medications, including over-the-counter (or attach list):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

List all vitamins and supplements:

_____ _____

_____ _____

List any allergies, including what the reaction was (rash, itching, etc.)

_____ _____

Last Page - almost finished!

Are you under the care of a psychiatrist or other mental health provider? .....❒Yes ❒No

Name of mental health provider.....

Have you had any problems with anesthesia? .....❒Yes ❒No

If “yes”, describe .....

Do you have a history of excessive bleeding?.....❒Yes ❒No

If “yes” to bleeding, give details: .....

What is your occupation? _____

If employed, part-time or full? _____

What is your marital status? _____

Review of Systems

Please check if you have the following:

❒ Fevers or chills
❒ Chest pain
❒ Bloody bowel movements
❒ Constipation
❒ Painful urination
❒ Bone pain
❒ Bleeding tendency
❒ Frequent headaches
❒ Excessive fatigue
❒ Difficulty breathing
❒ Diarrhea
❒ Acid reflux
❒ Leakage of urine
❒ Depression
❒ Skin problems
❒ Vision problems
❒ Anxiety

Which Surgery are you seeking at this time?

❒ Laparoscopic Gastric Bypass

❒ Laparoscopic Sleeve Gastrectomy

❒ Laparoscopic Adjustable Gastric Band (Lap-Band)

❒Switch - also known as “SADI-S” or “DS”

❒ No Preference

❒Not Sure

❒ Other_____

✔ Verification - Please sign and date

The information I have provided above on all pages is accurate and complete to the best of my knowledge.

Name _____

Signed_____Date _____