Welcome to

The FirstHealth Bariatric Center

Thank you for choosing FirstHealth. We recognize the courage it takes to gather in a public place to discuss something as personal as your weight. We understand that making the decision to proceed with bariatric surgery is one that takes a lot of contemplation and research. The physicians and staff of the Bariatric Center are pleased to have the opportunity to share information about our program and how we can help you succeed.

We have developed a multidisciplinary program focused on delivering excellent care to you throughout the entire process. FirstHealth Moore Regional Hospital has partnered with Pinehurst Surgical to provide education and support throughout the entire process and continues indefinitely since this is a lifelong, lifestyle change. Nutrition and exercise consultations, individual counseling and a support group are among the resources offered to ensure your success. When you are a patient of the FirstHealth Bariatric Center, you are not alone in your journey to good health!

Once again, we thank you for choosing the FirstHealth Bariatric Center. We look forward to serving you.

The Surgeons and Staff of FirstHealth Bariatric Center

SURGICAL PATHWAY TO WEIGHT-LOSS SURGERY

INFORMATION SESSION
Attend an in-person information session or complete the online video at www.NCWeightLossSurgery.org.

PATIENT PACKET
Complete entire packet and provide a copy of your insurance card(s) prior to being scheduled for consultation. You may submit the packet in three ways:

- Turn in at Nutrition class
- Fax: (910) 295-7946
- Mail: Pinehurst Surgical/Bariatric Program
- PO Box 2000, Pinehurst, NC 28374

NUTRITION CLASS
You are REQUIRED to attend a nutrition class. There is no charge for the class, and support persons are welcome to attend. Classes are held on Wednesdays at 8:45 a.m. or 3:45 p.m. on an alternating schedule. Please call the office at (910) 295-0884 to schedule your class.

BENEFITS
Once a copy of your insurance card has been provided, insurance information has been received and your consultation has been scheduled, the office will contact your insurance company to determine coverage for surgery.

- A Financial Counselor is available and will review your benefits and estimated cost with you.
- Feel free to call the 1-800# on the back of your insurance card to verify if you have bariatric surgery coverage. The CPT codes you will need to provide are Gastric Bypass 43644 or Gastric Sleeve 43775

CONSULT VISITS
You will be scheduled for nutritional and behavioral consultations on same day.

- 45-minute Nutritional Evaluation: Please bring a copy of your food dairy with you
- 45-minute Psychological Evaluation

Once your sessions are completed, you will be contacted by the team to schedule any follow-up visits required.

PRE-OPERATIVE CLEARANCES
You will then be informed of any required "specialty" clearances or follow-up required by the surgeon, bariatric team and/or your insurance carrier. These requirements vary widely and are based on your medical history and insurance policy. The Bariatric Navigator will assist you with referrals and appointment scheduling. Failure to keep scheduled appointments will result in surgery delays and/or cancellations. PLEASE be courteous and call to cancel your appointment if you cannot make your scheduled date/time.
EGD: A procedure to view your stomach to ensure it is safe to have surgery. You will need someone to drive you home the day of your procedure.

THREE PHYSICIAN LETTERS
You must submit three letters from your Primary Care doctor: Letter of Medical Necessity, Weight History Form and Letter of Medical Clearance

Obtaining these letters can take time so you are encouraged to begin working with your physician as soon as possible. Please fax to the Bariatric Patient Navigator at (910) 295-7946.

ONE MONTH PRIOR TO SURGERY
Upon completion of all scheduled appointments, you will begin preparation for surgery.

1. ATTEND PATIENT EDUCATION CLASS: This is a three-hour class. You are highly encouraged to bring a friend or family member who will be caring for you.
2. HISTORY & PHYSICAL: Required by your insurance company, must be within 30 days of surgery

TWO WEEKS PRIOR TO SURGERY
PRE-OP DIET: A two-week diet to prepare for your procedure taught at the Patient Education Class.

FINAL INSURANCE AUTHORIZATION – All of your test results and consultations will be submitted to your insurance company for final approval. Any expenses (co-pays, deductibles, out-of-pocket expenses) must be paid in full prior to your scheduled surgery.

Please complete the entire profile as accurately and thoroughly as possible to prevent any delays.

Date:_____

Last Name:_____ First Name:_____ Middle:_____

Date of Birth: _____

Religious Affiliation: _____

Home Address: _____ Apt._____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

I am interested in: __ Gastric Bypass Surgery __ Sleeve Gastrectomy __ Undecided at this time

SOCIAL PROFILE

Are you currently employed? __ YES __NO

Occupation: _____

Employer: _____

If employed, please state what level of activity your job involves:

__ Little (sedentary job) __ Moderately active __ Very active

PHYSICIAN

Primary Care Physician: _____

Name of Facility or Clinic: _____

Address: _____

Telephone # _____ Fax# _____

BARIATRIC PROGRAM MEDICAL HISTORY

PATIENT NAME:	DOB:		AGE:
INSURANCE:			
PCP:			
BLOOD DISORDER/HEMATOLOGY	**YES**	**NO**	**MEDICATIONS**
HIV POSITIVE			
HEPATITIS A,B,C			
ANEMIA			
BLOOD THINNERS (COUMADIN, Eliquis, Plavix, Aspirin			
CANCER			
• TYPE • YEAR DIAGNOSED			
CARDIAC			
HYPERTENSION (HIGH BLOOD PRESSURE0			
HYPERLIPIDEMIA (HIGH CHOLESTEROL)			
CORNORANY ARTERY DISEASE			
HEART ATTACK			
AFIB			
ENDOCRINOLOGY			
HYPOTHYROID			
HYPERTHYROID			
DIABETES • TYPE: • A1C			
GASTROINTESTINAL			
HEARTBURN/REFLUX			
BOWEL DISEASE			
IBS (IRRITABLE BOWLE DISEASE)			
CROHN'S DISEASE			
ULCER			
GASTROPARESIS			
GYNOCOLOGICAL			
INFERTILITY			
PCOS			
KIDNEY DISEASE			
INCONTINENCE			
RENAL FAILURE			
LIVER DISEASE			
• TYPE • TREATMENT			
MUSCULO-SKELETAL			
BODILY PAIN/JOINT PAIN			
RHEUMATOID ARTHRITIS			
ARTHRITIS			
OSTEOARTHRITIS			
GOUT			

BARIATRIC PROGRAM MEDICAL HISTORY

NEUROLOGY			
STROKE			
RESPIRATORY			
ASTHMA			
BREATHING PROBLEMS			
CHRONIC COUGHEMPHYSEMA			
SLEEP APNEA CPAP BIPAP			
BEHAVIORAL			
DEPRESSION			
ANXIETY			
PTSD			
ADD/ADHD			
BIPOLAR			
SCHIZOPHRENIA			
SUICIDE ATTEMPT			
ANOREXIA/BULEMIA			
SOCIAL			
ALCOHOL USE • TYPE • HOWMUCH/HOW OFTEN			
NICOTINE USE • TYPE • HOW MUCH/HOW OFTEN • YEARS OF USE • QUIT DATE			
PAST SURGICAL HISTORY			
CANCER • TYPE: • SURGERY:			
CARDIAC			
CARDIAC CATH/STENTS			
CORONARY BYPASS			
PACEMAKER/DEFIBRULATOR			
GASTROINTESTINAL			
PRIOR BARIATRIC PROCEDURE • TYPE • YEAR			
NISSEN FUNDOPLICATION (Hiatal Hernia Repair)			
OTHER HERNIA REPAIR			
APPENDECTOMY			
CHOLECYSTECTOMY			
BOWEL SURGERY			
GYNECOLOGICAL			
C-SECTION			
HYSTERECTOMY			

BARIATRIC PROGRAM MEDICAL HISTORY

KIDNEY			
NEPHRECTOMY			
MUSCULOSKELETAL			
BACK			
KNEE			
JOINT			
RESPIRATORY			
LUNG (LOBECTOMY)			

OTHER:

FAMILY MEDICAL HISTORY

FATHER

Please check one: __ Living: Age_____ __ Deceased at Age: _____
Cause of death: __Cancer __Accident __Age related __Diabetes
__Heart Disease/Stroke/Heart Attack
__Other: _____

History of Obesity __ Yes __No
Heart Disease __ Yes __No
Hypertension __Yes __ No
Diabetes __Yes __No
History of Cancer __Yes __No If Yes, what kind?
__Endomitrial __Prostate __Colon __Thyroid __ Skin
__Blood __Other: _____

MOTHER

Please check one: __ Living: Age_____ __ Deceased at Age: _____
Cause of death: __Cancer __Accident __Age related __Diabetes
__Heart Disease/Stroke/Heart Attack
__Other: _____

History of Obesity __ Yes __No
Heart Disease __ Yes __No
Hypertension __Yes __ No
Diabetes __Yes __No
History of Cancer __Yes __No If Yes, what kind?
__Endomitrial __Prostate __Colon __Thyroid __ Skin
__Blood __Other: _____

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BARIATRIC CENTER

AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATON (PHI)

Patient Name:_____ Date of Birth:_____

Full Address:_____

SSN:___-___-_____ Home Phone:(___)_____ Medical Record Number:_____

I, _____, do hereby authorize _____
Print Patient Name or Legal Representative Physician, Clinic, or Health Care Facility

to release individually identifiable Protected Health Information (PHI) to FirstHealth Moore Regional Hospital Bariatric Center and the Pinehurst General and Bariatric Surgical Center.

I hereby authorize the use and disclosure of PHI relating to me as described below:

☐Lab & X-Ray Reports ☐MRI Results ☐Clinic Notes ☐OP Reports

☐H&P ☐D/C Summary ☐ER Report ☐Pathology Report

☐X-Ray Films ☐CT Scans ☐MRI Films

☐Entire Chart # _____ ☐Other:_____

☐**I do** ☐**I do not** authorize release of information related to AIDS or HIV infection, psychiatric care and or psychological assessment, and treatment for alcohol and/or drug abuse.

Release Information to: Pinehurst Surgical
Department of General and Bariatric Surgery
5 FirstVillage Dr.
P.O. Box 2000
Pinehurst, NC 28374
FAX: (910) 295-7946

Authorized Protected Health Information will be used for continued care.

- At all times I have the right to revoke this authorization. Such revocation must be submitted in writing.
- I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of such information, and, at that point, the information may no longer be protected under the federal or state confidentiality rules.
- I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, and enrollment in a health plan, or eligibility for benefits.

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Signature of Witness Date

FirstHealth Moore Regional Hospital Bariatric Center

I am interested in having Raymond G. Washington, M.D. or David W. Grantham, M.D., perform bariatric surgery at FirstHealth Moore Regional Hospital. I request that you release any information to determine eligibility, benefits, co-payments or any out-of-pocket expenses.

I also give permission for any insurance company to inform Raymond G. Washington, M.D. or David W. Grantham, M.D., of Pinehurst Surgical Department of General and Bariatric Surgery, of the reasonable and customary reimbursements for my surgical procedure.

_____ _____

Signature of Patient or Legal Representative Date

_____

Print Name

Mail to: Pinehurst Surgical
Dept. of General and Bariatric Surgery
P.O. Box 2000
Pinehurst, NC 28374

Fax to: (910) 295-7946

AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY

Pinehurst Surgical
Department of General and Bariatric Surgery
P.O. Box 2000
Pinehurst, NC 28374

I, _____, (____/____/_____, _____ - _____ - _____),
Print Patient Name or Legal Representative Date of Birth Social Security Number

authorize representatives of the FirstHealth Moore Regional Hospital Bariatric Center and Pinehurst Surgical Department of General and Bariatric Surgery to discuss the confidential information of

_____with:
Print Patient Name

Name: _____Relationship:_____

Full Address:_____

_____

Home Phone:_____Cell:_____Work:_____

E-mail:_____ (required)

Name: _____Relationship:_____

Full Address:_____

_____

Home Phone:_____Cell:_____Work:_____

E-mail:_____ (required)

I authorize the staff of the FirstHealth Bariatric Center and Pinehurst Surgical Department of General and Bariatric Surgery to discuss my confidential information with those listed above in order to provide appropriate medical care and services. I understand that I can change my mind at any time and revoke my authorization in writing.

I further understand that the FirstHealth Bariatric Center staff and Pinehurst Surgical Department of General and Bariatric Surgery can reach me via the individuals listed above if my contact information changes.

_____ _____
Signature of Patient or Legal Representative Date

AUTHORIZATION TO RELEASE HEALTH INFORMATION

INSTRUCTIONS FOR COMPLETING FORM: Please write legibly and complete all sections **including witness signature** as indicated *(SS # optional)*. Return the completed and signed form to: **Health Information Management, Release of Information PO Box 3000, Pinehurst, NC 28374**

Printed Patient Name (Last, First, Middle Initial)	Birth Date (MM/DD/YYYY)	Social Security Number	MR# -Internal Use
Mailing Address (Include Street/PO Box, City and Zip Code)			Telephone# (Including Area Code) ( )
Date/s of Treatment Covered Under Request	Date Copies Needed By		Mail ☐ Pick-up ☐ (Positive ID Required)

I hereby authorize: ☐ **FirstHealth** – /Pinehurst Surgical Bariatrics

☐ _____

to release copies of records on the above patient to ☐ myself ☐ Other ATTN: _____

ADDRESS _____

(Indicate complete mailing address if different from patient address).

PHONE NUMBER _____ **FAX NUMBER** _____

INFORMATION TO BE RELEASED INCLUDES (*Check applicable box/s and indicate other information in the space below. Please also be aware that you may be charged for any records copied*):

☐ ED Physician Report	☐ Operative Report/s	☐ EKG Report/s	☐ Abstract (All MD dictations & diagnostics)
☐ History and Physical	☐ Pathology Report/s	☐ X-ray Report(s)	☐ Complete Record
☐ Discharge Summary	☐ Laboratory Report/s	☐ X-ray Films	☐ Record Review Request
☐ Consultation Report/s	☐ Other _____		

BY INITIALING BELOW, I further authorize release of information that may be present in my record to include information related:

_____ Alcohol or drug abuse, _____ Mental or behavioral health or psychiatric care,

_____ AIDS and/or HIV diagnoses _____ Psychotherapy session notes and records

PURPOSE OF RELEASE _____

I understand that this authorization is voluntary and that I may refuse to sign it. I need not sign this form to ensure healthcare treatment or payment for such treatment.

This authorization is void 180 days after the date signed or anytime I, as the patient, guardian, or legally authorized representative make a **specific written request to the entity noted above to revoke** the authorization. Such revocation shall be effective *except* to the extent that the facility has already used or disclosed information in reliance on the authorization.

I understand that once information is used or disclosed based on this authorization it may be re-disclosed by the recipient and at such time may no longer be protected by federal privacy laws or regulations.

_____	_____	_____
Signature of Patient/*Individual With Legal Authority to Sign**	**Date**	**Time**
_____	_____	_____
Signature of Witness	**Date**	**Time**

******THE FOLLOWING SECTION MUST BE COMPLETED WHENEVER PATIENT IS UNABLE TO PERSONALLY SIGN FOR RELEASE OF PROTECTED HEALTH INFORMATION.***

Patient is unable to authorize release of records/information as a result of the following **(check one):**

☐ Patient is a minor, ☐ Patient is mentally incompetent, ☐ Patient has a physical disability that prohibits signing, or

☐ Deceased/Other (clearly state reason if other) _____

NOTE: If the patient is deceased, only the executor and/or administrator of the estate or next-of-kin may authorize release of copies of medical records. Documentation reflecting such individuals' legal authority to sign for release of records must be provided.

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Authorization to Release Health Information

1ROI001

Place Patient Label Inside This Box