Welcome to the Louisiana Center for Weight Loss Surgery!

Steps in the Process:

1. **We will confirm your insurance coverage for bariatric surgery.**

    - Do you have a weight loss benefit as part of your insurance coverage? Most programs require a documented six-month, medically supervised weight loss program. There may also be other requirements.

    - If your insurance carrier requires a six-month, medically supervised weight loss program, we will work with you to initiate this.

2. **If you do not have insurance coverage for weight loss surgery, we do offer special pricing for advance payment.**

3. **Complete the new patient packet.** You must fill out this packet and bring it with you to the initial consult. At this visit, we will discuss any additional steps that you will need to complete before surgery.

Welcome to the Louisiana Center for Weight Loss Surgery!

We have cash price packages for our patients who do not have insurance that will cover bariatric surgery.

Sleeve Gastrectomy: $12,900

- **Facility Fee**

  This includes the hospital stay as well as some pre-operative testing. This fee also includes a pre-op and post-op visit with our dietician. This fee does not include professional physician fees, which might be necessary.

- **Both the anesthesia fee and the surgeon fee, which apply only to the actual procedure, are included.**

  Please note: Patients may require special diagnostic testing or consultations before and/or after surgery that would not be included in the $12,900 fee. For example, a sleep study or a cardiology consultation would be considered an additional expense.

- **Follow-up lab work for nutritional assessment is considered an additional fee.**

- **A pre-operative psychological evaluation is required prior to surgery. This is an additional fee of approximately $295. Please contact Dr. Terry Thomas at 318-998-2700 to schedule your appointment.**

Welcome to the Louisiana Center for Weight Loss Surgery!

Diet History:

What age did you start to diet?_____ Age when obesity began?_____

Check yes or no			Dates	Duration	MD Supervision?		Max weight lost?
Jenny Craig	Yes	No			Yes	No	
O.A.	Yes	No			Yes	No	
Meridia	Yes	No			Yes	No	
Fen/Phen/Redux	Yes	No			Yes	No	
Weight Watchers	Yes	No			Yes	No	
Nutri-Systems	Yes	No			Yes	No	
Adipex	Yes	No			Yes	No	
List others:							
					Yes	No	
					Yes	No	
					Yes	No	

Tell us about the diets that you have tried:

Does obesity interfere with your daily activities?

Walking?	☐ Yes	☐ No
Providing childcare?	☐ Yes	☐ No
Dressing?	☐ Yes	☐ No
Picking up things/bending over?	☐ Yes	☐ No
Climbing stairs?	☐ Yes	☐ No
Working?	☐ Yes	☐ No
Standing?	☐ Yes	☐ No
Housework?	☐ Yes	☐ No
Playing?	☐ Yes	☐ No
Sex?	☐ Yes	☐ No
Tying Shoes?	☐ Yes	☐ No
Cleaning Self?	☐ Yes	☐ No
Sitting?	☐ Yes	☐ No
Bathing?	☐ Yes	☐ No
Exercising?	☐ Yes	☐ No
Shopping?	☐ Yes	☐ No
Traveling?	☐ Yes	☐ No

Provide a description of how obesity affects your daily activities:

The Surgery Clinic of Northeast Louisiana

PATIENT INFORMATION: Date of Appointment _____

How did you hear about us? ☐TV ☐Radio ☐Direct Mail ☐Newspaper ☐Friend/Family ☐Physician ☐Website ☐Health Fair

Referred by: _____ Primary Care Doctor: _____

Patient's Name: _____
First Middle Last Preferred

Address: _____
Number and Street Apt/Lot City State Zip

SSN: _____-_____-_____ Date of Birth: _____ Marital Status: _____

☐Male ☐Female Race: _____ Language: _____ Email: _____

Home Phone: _____ Cell Phone: _____ Work Phone:_____

Best Way to contact you: Phone☐ Email☐ Do you Have Insurance: Yes ☐ No ☐

Employer: _____ Occupation: _____School: _____

PAYMENT INFORMATION:

Person Responsible for Payment/bill: _____
First Middle Last

Address: _____ _____
Number and Street Apt/Lot City State Zip Main Phone

Relationship to Patient: _____ SSN: _____ -_____-_____ Date of Birth: _____

Best Way to Contact Individual: Phone☐ Mail☐ Email Address: _____

INSURANCE INFORMATION:

Insurance Company: _____ Policy Number: _____

Policyholder's Name: _____
First Middle Last

Address: _____
Number and Street Apt/Lot City State Zip

Relationship to Patient: _____ SSN: _____-_____-_____ Date of Birth: _____

Main Phone: _____ 2nd Phone: _____ Email: _____

Employer: _____ Occupation: _____

2nd Insurance Company: _____ Policy Number: _____

PATIENT'S CONTACTS:

Pharmacy: _____ Location: _____

Legal Guardian: _____
Name Relationship Main Phone 2nd Phone

Primary Caregiver: _____
Name Relationship Main Phone 2nd Phone

Emergency Contact: _____
Name Relationship Main Phone 2nd Phone

All professional services rendered are the financial responsibility of the patient. Payment is expected upon the provision of services. For insured patients, we are pleased to assist in the filing of your insurance claims. *By signing below, I hereby consent to my insurance carrier releasing all necessary information to The Surgery Clinic of Northeast Louisiana regarding the status of my claims. Further, I hereby authorize The Surgery Clinic of Northeast Louisiana to furnish information to my insurance carrier concerning my medical history, illness and treatments. Further, I authorize my insurance carrier to pay directly to The Surgery Clinic of Northeast Louisiana all benefits to which I and/or my dependents may be eligible for the provision of healthcare services.

I HAVE READ, UNDERSTAND, AND AGREE TO THE PROVISIONS ABOVE

SIGNATURE: _____

DATE: _____

CONSENT:

I hereby voluntarily give consent for the necessary medical treatment for the above named patient.

_____
Signature of Legal Guardian

_____
Date

The Surgery Clinic of Northeast Louisiana

CONSENT FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule") establishes a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services issued the Privacy Rule to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). HIPAA's privacy rules generally give you the right to request a restriction on uses and disclosures of your protected health information (PHI). You are also provided the right to request confidential communication or that a communication of PHI be made by alternative means, such as sending correspondence to your office instead of your home. To better serve you, please complete the following:

PLEASE CONTACT ME IN THE FOLLOWING MANNER:

VERBAL COMMUNICATION:
Home / Cell / Work
Please Identify Your Preferred Phone Number: (____) ____- _____

☐ Leave message with detailed information.

☐ Leave message with call back number only.

WRITTEN COMMUNICATION:

☐ Mail to this address: _____

☐ Fax to this number: _____

☐ Email address: _____

FAMILY MEMBER(S) OR FRIEND(S) WITH WHOM WE MAY DISCUSS YOUR MEDICAL CONDITION:

Name: _____ Address: _____ Phone: _____
Relationship: _____
Name: _____ Address: _____ Phone: _____
Relationship: _____
Name: _____ Address: _____ Phone: _____
Relationship: _____
Name: _____ Address: _____ Phone: _____
Relationship: _____

I understand it is my responsibility to provide this office with written changes to the release of my PHI.

Patient's Printed Name: _____

Patient Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES
The Surgery Clinic of Northeast Louisiana

The attached information describes how information about you may be used and disclosed and how you gain access to this information. Please review it carefully.

UNDERSTANDING YOUR HEALTH RECORD INFORMATION

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit should be made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care. This information is often referred to as your health or medical records and serves as a basis for planning your care and treatment. These records foster communications among the healthcare professionals who may contribute to your care. These records also provide a means by which you or a third party payer can verify that services billed were actually provided.

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, hereby authorize **The Surgery Clinic of Northeast Louisiana** to use or carry out my treatment, payment and healthcare operations. I understand this consent is voluntary. If I refuse to sign this consent, I understand **The Surgery Clinic of Northeast Louisiana** may refuse to treat me.

I understand that I may revoke this consent at any time by notifying **The Surgery Clinic of Northeast Louisiana** in writing. If I revoke my consent, such revocation shall not affect any actions that **The Surgery Clinic of Northeast Louisiana** may have taken prior to receiving notice of my revocation.

I understand that **The Surgery Clinic of Northeast Louisiana** has reserved the right to change its privacy practices and that I may obtain such revised information upon request.

I understand that I have the right to request that **The Surgery Clinic of Northeast Louisiana** restrict how my individually identifiable health information is used and disclosed to carry out treatment, payment, and health operations. I understand that **The Surgery Clinic of Northeast Louisiana** is not obligated to agree to such restrictions, but that once such restrictions are agreed to **The Surgery Clinic of Northeast Louisiana** shall adhere to such restrictions.

The following notice describes how your medical information may be used and disclosed, and how you can gain access to this information. Please review the information carefully.

Your confidential healthcare information may be released to:

- Other healthcare professionals for the purpose of providing you with quality healthcare.
- Your insurance provider for the purpose of **The Surgery Clinic of Northeast Louisiana** receiving payment for providing you with needed healthcare services.
- Public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime, or domestic violence.
- Other healthcare providers in the event you need emergency care.
- A public health organization or federal organization in the event of a communicable disease, to report a defective device, untoward event to a biological product (food or medication), or other statutory reporting requirements.

Your confidential healthcare information may not be released for any other purpose than that which is identified in this notice.

Your confidential healthcare information may be released only after receiving written authorization from you. You may revoke your permission to release confidential healthcare information at any time.

You may be contacted by **The Surgery Clinic of Northeast Louisiana** to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.

You have the right to:

- Restrict the use of your confidential healthcare information. However, **The Surgery Clinic of Northeast Louisiana** may choose to refuse your restriction if it is in conflict with providing you with quality healthcare, in the event of an emergency situation, or in conflict with state or federal requirements.
- Receive confidential communication about your health status.
- Review and photocopy any/all portions of your healthcare information.
- Make changes to your healthcare information.
- Know who has accessed your confidential healthcare information and for what purpose.
- Possess a copy of this Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.

The Surgery Clinic of Northeast Louisiana is required by law to protect the privacy of its patients. It will keep confidential any and all patient healthcare information.

The Surgery Clinic of Northeast Louisiana will abide by the terms of this notice. **The Surgery Clinic of Northeast Louisiana** does reserve the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information. The latest revision of the Notice of Privacy Practices will be available upon request.

You have the right to file a grievance with **The Surgery Clinic of Northeast Louisiana** if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please send your complaint to:

The Surgery Clinic of Northeast Louisiana
312 Grammont St. Suite 303
Monroe, LA 71201

All grievances will be investigated.

For further information about this Privacy Notice, please contact:

The Surgery Clinic of Northeast Louisiana
(318)398-2984

This notice is effective as of November 1, 2018.

Printed Name of Patient: _____

Signature of Patient/Representative: _____

Date: _____

The Surgery Clinic of Northeast Louisiana

Patient Name: _____

CONSENT TO TREATMENT

1. I hereby voluntarily consent to care at and by The Surgery Clinic of Northeast Louisiana, which may encompass certain routine out-patient procedures and certain diagnostic procedures, examinations and medical treatment including but not limited to routine laboratory work (such as blood, urine, and other studies), and administration of medications prescribed by the provider.
2. I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by The Surgery Clinic of Northeast Louisiana and its providers as is necessary in the medical staff's judgment.
3. If attached, I have reviewed and understand the supplemental information provided by my physician regarding specific treatment and/or procedures that may be provided.
4. In consenting to treatment, you are authorizing The Surgery Clinic of Northeast Louisiana to send you appointment reminders through automated phone calls and/or text messages. If at any time you no longer want to receive appointment reminders, please advise us in writing (email or letter), and we will discontinue that service.
5. I understand that The Surgery Clinic of Northeast Louisiana consists of specialty healthcare providers. The Surgery Clinic of Northeast Louisiana maintains its records electronically. This allows my medical information to be available throughout The Surgery Clinic of Northeast Louisiana.
6. I hereby authorize my insurance carrier(s) to pay The Surgery Clinic of Northeast Louisiana, all benefits due me, if any, by reason of service described in the statements rendered and as provided for by the policy contract with my insurance carrier(s).
7. I understand that this Consent Form will be valid and remain in effect as long as I (he/she) attend The Surgery Clinic of Northeast Louisiana.
8. This form has been explained to me, along with any attachment, and I understand their contents.

_____ _____

Signature of Patient or Person Authorized to Consent for Patient — Date

---

If patient is a minor or is unable to consent, _____

Patient Name

A. Patient is a minor _____ years of age. Name of legal Guardian _____

B. Patient is unable to consent because _____

_____ _____

Signature of Person Authorized to Consent for Patient — Relationship

REQUIRED RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of medical information necessary to process my claim. As a courtesy to The Surgery Clinic of Northeast Louisiana's patients, we will file the claim with your insurance carrier with the understanding that if your insurance company does not pay, you are responsible for payment of this account.

Patient (or Guardian): _____ _____

Print Sign Date

The Surgery Clinic of Northeast Louisiana

Authorization to Release or Obtain Health Information	
Name:	Request Date:
Mailing Address:	Date of Birth:
City/State/Zip:	Medicaid ID# or Social Security #:

The below section is to be filled out in the clinic. Please scroll to the bottom and sign this document.

I authorize:
Name:_____

Mailing Address:_____

City, State, Zip Code:_____

Relationship:_____ Telephone Number:_____

☐ **TO RELEASE INFORMATION TO** **OR** ☐ **TO OBTAIN Information FROM**
(Place an "X" in the box that indicates if the information is being released OR requested.)

Name:_____

Mailing Address:_____

City, State, Zip Code:_____

Relationship:_____ Telephone Number:_____

The **Purpose of this Authorization** is indicated in the box(es) below. (Place an "X" in the box(es) that apply.)

☐ Further Medical Care ☐ Personal ☐ Legal Investigation or Action ☐ Changing Physicians

☐ Research related treatment ☐ Creating health information for disclosure to third party ☐ Other_____

I authorize the release of the following protected health information.
(Place an "X" in the box(es) that apply to the information you want released or you want to obtain.)

☐ Entire Record ☐ Medical History, Examination, Reports ☐ Surgical Reports ☐ Treatments or Tests

☐ Prescriptions ☐ Immunizations ☐ Hospital Records including Reports ☐ Laboratory Reports

☐ X-Ray Reports ☐ Other:_____

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records:

☐ Alcoholism ☐ Drug Abuse ☐ Mental Health ☐ Vocational Rehabilitation ☐ HIV (AIDS)

☐ Sexually Transmitted Diseases ☐ Genetics ☐ Psychotherapy Notes ☐ Other:_____

This authorization shall expire on _____ (date or event) and is needed for the period beginning _____ and ending _____.

I understand that if I do not specify an expiration date, this authorization will expire six (6) months from the date on which it was signed. I acknowledge that I have read this form.

_____ _____ _____
Signature of Individual or Personal Representative Authorized by Law | Relationship to Patient | Date

_____ _____
Signature of Witness (if signed with an ("X") or mark) | Date

Patient History Form

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Height: _____ Weight: _____ Referring Doctor: _____ Primary Doctor: _____

1. Chief Complaint (The main reason you are seeing the doctor today)

_____

_____

2. Review of Systems (If patient is **currently experiencing**, please check Yes or No)

CONSTITUTION

Fever	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Weight loss	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No
Abnormal Sweating	☐ Yes	☐ No

SKIN

Rash	☐ Yes	☐ No
Itching	☐ Yes	☐ No

EARS, NOSE, AND THROAT

Hearing loss	☐ Yes	☐ No
Ringing in ears	☐ Yes	☐ No
Ear pain	☐ Yes	☐ No
Ear discharge	☐ Yes	☐ No
Nosebleeds	☐ Yes	☐ No
Congestion	☐ Yes	☐ No
Sinus pain	☐ Yes	☐ No
Sore throat	☐ Yes	☐ No

EYES

Blurred vision	☐ Yes	☐ No
Double vision	☐ Yes	☐ No
Photophobia	☐ Yes	☐ No
Eye pain	☐ Yes	☐ No
Eye discharge	☐ Yes	☐ No
Eye redness	☐ Yes	☐ No

CARDIOVASCULAR

Chest Pain	☐ Yes	☐ No
Palpitations	☐ Yes	☐ No
Orthopnea	☐ Yes	☐ No
Claudication	☐ Yes	☐ No
Leg swelling	☐ Yes	☐ No

RESPIRATORY

Cough	☐ Yes	☐ No
Coughing up blood	☐ Yes	☐ No
Productive cough	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No

GASTROINTESTINAL

Heartburn	☐ Yes	☐ No
Nausea	☐ Yes	☐ No
Vomiting	☐ Yes	☐ No
Abdominal pain	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Blood in stool	☐ Yes	☐ No

GENITOURINARY

Pain with urination	☐ Yes	☐ No
Urgency	☐ Yes	☐ No
Frequency	☐ Yes	☐ No
Blood in urine	☐ Yes	☐ No

MUSCULOSKELETAL

Muscle pain	☐ Yes	☐ No
Neck pain	☐ Yes	☐ No
Back pain	☐ Yes	☐ No
Joint pain	☐ Yes	☐ No
Falls	☐ Yes	☐ No

ENDOCRINOLOGY

Easy bruise/bleed	☐ Yes	☐ No
Env allergies	☐ Yes	☐ No
Excess thirst	☐ Yes	☐ No

NEUROLOGY

Dizziness	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Tingling / numbness	☐ Yes	☐ No
Tremor	☐ Yes	☐ No
Sensory change	☐ Yes	☐ No
Speech change	☐ Yes	☐ No
Weakness	☐ Yes	☐ No
Seizures	☐ Yes	☐ No

PSYCHOLOGY

Depression	☐ Yes	☐ No
Suicidal ideas	☐ Yes	☐ No
Substance abuse	☐ Yes	☐ No
Hallucinations	☐ Yes	☐ No
Nervous / Anxious	☐ Yes	☐ No

3. Medical History (**PATIENT'S** past medical history)

Allergies: _____

Anemia	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
CHF	☐ Yes	☐ No
Clotting disorder	☐ Yes	☐ No
COPD	☐ Yes	☐ No
Coronary artery disease	☐ Yes	☐ No
Dementia	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Dialysis	☐ Yes	☐ No

Fibromyalgia	☐ Yes	☐ No
GERD (Reflux)	☐ Yes	☐ No
Heart attack	☐ Yes	☐ No
Heart disease	☐ Yes	☐ No
HIV / AIDS	☐ Yes	☐ No
High cholesterol	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Kidney disease	☐ Yes	☐ No
Lupus	☐ Yes	☐ No
Meningitis	☐ Yes	☐ No

Rheumatoid arthritis	☐ Yes	☐ No
Seizure disorder	☐ Yes	☐ No
Sickle cell anemia	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Substance abuse	☐ Yes	☐ No
Thyroid disease	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No

Other: _____

_____

_____

4. Past Surgical History (Please list all operations or procedures patient has had along with the dates)

_____

_____

5. Social History (**Patient's** social history)

Do you use nicotine?	☐ Currently	☐ Previous	☐ Never	Explain: _____
Do you drink alcohol?	☐ Currently	☐ Previous	☐ Never	Explain: _____
Do you use drugs?	☐ Currently	☐ Previous	☐ Never	Explain: _____
Are you sexually active?	☐ Currently	☐ Previous	☐ Never	Birth control: _____

6. Family History (please list any medical conditions for patient's **blood** relative) ☐ Adopted ☐ Family History Unknown

Mother: _____ Maternal Grandparent: _____

Father: _____ Paternal Grandparent: _____

Siblings: _____ Other: _____

Today's Date: _____

Medication List

Patient's Name: _____ Date Of Birth: _____

Allergies: _____

Pharmacy: _____

Medication	Dose	Instructions