Trinity Bariatric Surgery
Buffalo's Weight Loss Surgical Solution

PATIENT INFORMATION

OFFICE USE ONLY	
	HIPAA
	No-Show form
	Patient Financial form
	Referral
LRYGB / LVSG / LAGB / DOS:	

SELF			
LAST NAME	FIRST		
ADDRESS			
CITY			
DATE OF BIRTH			
PLEASE LIST PREFERRED NUMBER OF CONTACT			
HOME PHONE: ( ) -	CAN WE LEAVE A MESSAGE AT YOUR **HOME** #?	☐ YES	☐ NO
WORK PHONE: ( ) -	CAN WE LEAVE A MESSAGE AT YOUR **WORK** #?	☐ YES	☐ NO
CELL PHONE: ( ) -	CAN WE LEAVE A MESSAGE AT YOUR **CELL** #?	☐ YES	☐ NO
	MAY WE SEND AN APPOINTMENT REMINDER TEXT?	☐ YES	☐ NO
E-MAIL ADDRESS			

PRIMARY CARE PHYSICIAN		
PHYSICAN	PHONE	FAX
ADDRESS		
PHARMACY		
PHARMACY	PHONE	FAX
ADDRESS		
EMERGENCY CONTACT		
NAME	PHONE	RELATION
NAME	PHONE	RELATION
PEOPLE WE ARE **NOT** ALLOWED TO SPEAK WITH REGARDING YOUR CARE (IF APPLICABLE):		
NAME	RELATION	

PRIMARY INSURANCE COMPANY	
INSURANCE COMPANY NAME	
POLICYHOLDER'S NAME	
RELATIONSHIP TO PATIENT	
POLICY NUMBER	GROUP/PLAN NUMBER
SECONDARY INSURANCE COMPANY	
INSURANCE COMPANY NAME	
POLICYHOLDER'S NAME	
RELATIONSHIP TO PATIENT	
POLICY NUMBER	GROUP/PLAN NUMBER

Allergies: Are you allergic to any drug, food or substance? If yes, please list and explain what the reaction is (swelling, hives, rash, etc.)	

I certify that the above information is correct and up to date. If there should be any discrepancies, I will notify the medical staff to make the appropriate changes. I understand the information above will not be released to any other third party.

X_____ DATE_____

HIPAA Privacy Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow Trinity Bariatric Surgery (TBS) to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare options, and coordination of care. As an example, the patient agrees to allow TBS to submit PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that TBS will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. TBS will do its best to honor those requests and restrictions but is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any given care after the request has been presented.
5. For your security and right to privacy, all staff have been trained in the area of patient records privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by TBS to assure that your records are not readily available to those who do not need them.
6. Patient has the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, TBS has the right to refuse to give care.

I have read and understand the HIPAA Notice of Privacy Practices and I agree to these policies and procedures.

Print Name: _____

Signature: _____

Date: _____

Trinity Bariatric Surgery

Buffalo's Weight Loss Surgical Solution

Patient Responsibility

I understand that if I have a copayment through my insurance or an outstanding balance is due on my account, the payment will need to be collected at the time of my visit or my appointment will be rescheduled.

I understand that if I have not provided my most current Health Insurance information at each visit, or if my Health Insurance denies coverage for any services rendered, I may be financially responsible for these services and/or services ordered by my Trinity Bariatric Surgery (TBS) provider.

I also understand that my insurance may have a deductible along with a hospital copayment for which I am responsible for.

Medicare patients will be responsible for 20% of charges which must be paid in full 90 days from receipt of billing statement.

I understand that if for any reason I should need emergent care and see a provider, my insurance copayment, if applicable, will be due at the time of every visit unless covered under the 90-day global coverage.

I also understand my insurance policy may only provide coverage for services that are deemed medically necessary. If I receive services that my insurance company determines are not medically necessary, TBS may seek payment for me for these services.

_____

Patient Name (Please Print)

_____ _____

Patient Signature Date

2625 Harlem Road, Suite 160, Buffalo, New York 14225
Tel: (716) 893-0333 / Fax: (716) 893-3038
BuffaloWeightLossSurgery.com

Trinity Bariatric Surgery

Buffalo's Weight Loss Surgical Solution

"NO SHOW" Policy

Trinity Bariatric Surgery (TBS) has a "no show" policy. You will be considered a "no show" if an appointment is missed or cancelled with less than 24 hours notice. When this occurs, our facility loses the opportunity to care for other patients who wish to be seen. If 24 hours notice is not received, a fee of $35.00 will be charged to your account. This fee is not covered by insurance and is therefore your sole responsibility. If you arrive 15 minutes or later for your scheduled appointment time, you may be asked to reschedule out of respect for the time of the patients who arrived on time for their appointments.

I, _____ understand and acknowledge that TBS has a policy to charge me a $35.00 fee if I fail to show up for a scheduled appointment in a timely manner, or if I cancel my scheduled appointment with less than 24 hours notice. I agree to pay this fee if necessary, and understand I will be unable to schedule future appointment until the fee is paid. It is therefore my responsibility to keep track of the appointments I schedule. While TBS may send appointment reminders as a courtesy, it is not the facility's duty to notify me of upcoming appointments.

_____ _____

Patients Signature Date

2625 Harlem Road ● Suite 160 ● Buffalo ● New York 14225
Tel: (716) 893-0333 ● Fax (716) 893-????
www.BuffaloWeightLossSurgery.com

Trinity Bariatric Surgery

Buffalo's Weight Loss Surgical Solution

Smoking, Weight Loss Surgery and YOU!

If you smoke, your bariatric surgeon will require you to stop smoking at least 8 weeks before your surgery. This is because patients who smoke are at a higher risk of having surgical complications, anesthesia complications, and are more likely to develop pneumonia after surgery. Smoking also contradicts the purpose of weight loss surgery, which is about improving your overall health and quality of life.

We understand there a number of reasons why it is difficult to stop smoking. Nicotine is the drug in tobacco products that causes dependence. Patients who smoke, even in moderation, are dependent on nicotine. Nicotine dependence is the most common form of chemical dependence in the United States. There are many health risks associated with smoking. Bariatric patients who have smoked for a long period of time fear gaining extra pounds once they quit smoking. We also understand this is a time of stress because you are busy preparing for your upcoming surgery and anticipating the lifelong changes that follow. Regardless, we understand the effort involved but believe the risks of smoking are great and the benefits of smoking cessation far outweigh these inconveniences.

We want to help you reach your goals. So, here are some tips:

1) First let's talk about why patients gain weight after they quit smoking:
   - Changes in the metabolic rate: Nicotine raises the metabolic rate; this temporarily slows after smoking cessation. Your body will burn off fewer calories, which causes the tendency to gain weight in some patients.
   - Changes in eating habits: Patients are more inclined to eat sweet or fatty foods or eat more because food simply tastes better as taste buds reactivate.
   - Oral cravings: Many patients who have recently stopped smoking report that they miss the feeling of having something in their mouth. This could lead to snacking or mindless eating.

2) Take advantage of the 8 weeks before surgery to make adjustments to your eating and exercise habits**.**
   - Discuss options for weight management with your dietician
   - Discuss STOP SMOKING behavioral counseling with your counselor
   - Discuss pharmaceutical options with your doctor
   - Get active!

Please be advised that there will be a preoperative nicotine blood test and if it is positive your bariatric surgeon in concert with the anesthesia team may have to postpone or cancel your surgery.

Date _____

Patient Name (Please Print) _____

Patient signature_____

2625 Harlem Road, Suite 160, Buffalo, New York 14225
Tel: (716) 893-0333 / Fax: (716) 893-3038
BuffaloWeightLossSurgery.com

Trinity Bariatric Surgery

Buffalo's Weight Loss Surgical Solution

Understanding Pregnancy, Fertility, and Weight Loss Surgery

This Patient Contract is provided to ensure that you fully understand that women of childbearing age who have had weight loss surgery must take special precautions in avoiding pregnancy for a designated period of time after weight loss. Weight loss due to bariatric surgery often increases fertility in those whom have had difficulty conceiving in the past. With that in mind, please complete following.

Please indicate that you understand and agree with the statements below by initialing in the space to the left of the statement.

_____1. I understand that one of the goals of this Patient Contract is to help my bariatric team members understand that I commit to avoid pregnancy until discussed and cleared with my surgeon and obstetrician.

_____2. I understand and agree that pregnancy should not be attempted until weight loss and nutritional intake have stabilized.

_____3. As a woman of childbearing age who seeks to have weight loss surgery, I commit to using two reliable birth control methods during the period of rapid weight loss.

_____4. I understand that maternal malnutrition may impair normal fetal development.

_____5. When I become pregnant, I understand the importance of prenatal vitamins and other supplements and agree to take the prescribed amounts prior to and for the entire pregnancy as recommended by my dietician or obstetrician.

_____6. I expect to delay pregnancy for ***at least*** 18 months after surgery.

_____7. I agree to discuss my procedure, the need for birth control, and my commitment to avoid pregnancy with my significant family members.

_____8. When I become pregnant, I can expect that my surgeon and obstetrician will order special testing and treatments that could result in additional costs.

Patient Name (printed): _____

Signature:_____ Date:_____

2625 Harlem Road, Suite 160, Buffalo, New York 14225
Tel: (716) 893-0333 / Fax: (716) 893-3038
BuffaloWeightLossSurgery.com