BELTLINE HEALTH
WEIGHT LOSS SOLUTIONS

PATIENT PAPERWORK

PATIENT INFORMATION		
Full Name: [First]	[M.I.]	[Last]
Date of Birth: / /		**Sex:** ○ Male ○ Female
Social Security #:		
Street Address:		**Apt # / Suite #:**
City:	**State:**	**Zip:**
Primary Insurance:		**Policy ID #:**
Secondary Insurance:		**Policy ID #:**

CONTACT INFORMATION	
Please make sure you register for the patient portal and check for any messages received! **This is the primary means of communication with the practice.**	
Mobile Phone #:	**Home Phone #:**
Email Address: You should have received an emailed invite to register for the patient portal. Please ask the front office if you have not received this.	
Emergency Contact & Relationship:	**Phone #:**

REFERRAL INFORMATION		
How did you hear about Beltline? ☐Google	☐Friend/Family	☐Doctor
☐TLC TV Series	☐Social Media	☐TV Commercial
Referring Doctor:		**Phone #:**
Practice Name / Address:		
Primary Care Doctor:		**Phone #:**
Practice Name / Address:		

RECEIPT OF PRIVACY PRACTICES		
I have been offered a copy of the Privacy Practices Policy of Beltline Health. *(See the last page.)*		
☐I accept a copy of the policy / ☐I decline a copy of the policy.		
Signature:	**Printed Name:**	**Date:**

BELTLINE HEALTH
WEIGHT LOSS SOLUTIONS

FAMILY MEDICAL HISTORY | SLEEP STUDY QUESTIONNAIRE

Name:	**Date of Birth:** / /
Reason for Visit:	**Today's Date:**

FAMILY HISTORY				
	FATHER	**MOTHER**	**G.FATHER**	**G.MOTHER**
NO CONDITIONS	☐	☐	☐	☐
Abdominal Pain (R10.9)	☐	☐	☐	☐
Anemia (D64.9)	☐	☐	☐	☐
Anxiety (F41.9)	☐	☐	☐	☐
Asthma (J45.909)	☐	☐	☐	☐
Blood Clots (I74.9)	☐	☐	☐	☐
Cancer (C80.1)	☐	☐	☐	☐
Depression (F32.9)	☐	☐	☐	☐
Diabetes (E11.9)	☐	☐	☐	☐
Epilepsy / Seizures (G40.901)	☐	☐	☐	☐
Fatty Liver (K76.0)	☐	☐	☐	☐
Gallbladder Disease (K82.9)	☐	☐	☐	☐
GOUT (M10.9)	☐	☐	☐	☐
Heart Disease (I51.9)	☐	☐	☐	☐
HIV / AIDS (B20)	☐	☐	☐	☐
Hypertension (I10)	☐	☐	☐	☐
Hyperthyroidism (E05.90)	☐	☐	☐	☐
Hypothyroidism (E03.9)	☐	☐	☐	☐
Kidney Disease (N18.9)	☐	☐	☐	☐
Lung Disease (J84.9)	☐	☐	☐	☐
LVAD (I50.1)	☐	☐	☐	☐
Osteoarthritis (M19.91)	☐	☐	☐	☐
Sleep Apnea (G47.30)	☐	☐	☐	☐
Stomach Ulcers (K63.3)	☐	☐	☐	☐
Stroke (I63.9)	☐	☐	☐	☐
Thyroid Cancer (C73)	☐	☐	☐	☐

BELTLINE HEALTH
WEIGHT LOSS SOLUTIONS

PERSONAL MEDICAL HISTORY

Name:	Date of Birth: / /

CURRENT MEDICAL CONDITIONS	SELF
NO CONDITIONS	☐
Abdominal Pain (R10.9)	☐
Anemia (D64.9)	☐
Anxiety (F41.9)	☐
Asthma (J45.909)	☐
Blood Clots (I74.9)	☐
Cancer (C80.1)	☐
Depression (F32.9)	☐
Diabetes (E11.9)	☐
Epilepsy / Seizures (G40.901)	☐
Fatty Liver (K76.0)	☐
Gallbladder Disease (K82.9)	☐
GOUT (M10.9)	☐
Heart Disease (I51.9)	☐
HIV / AIDS (B20)	☐
Hypertension (I10)	☐
Hyperthyroidism (E05.90)	☐
Hypothyroidism (E03.9)	☐
Kidney Disease (N18.9)	☐
Lung Disease (J84.9)	☐
LVAD (I50.1)	☐
Osteoarthritis (M19.91)	☐
Sleep Apnea (G47.30)	☐
Stomach Ulcers (K63.3)	☐
Stroke (I63.9)	☐
Thyroid Cancer (C73)	☐

SURGICAL HISTORY		
Bariatric surgery?	☐Yes ☐No	**When:** **Type:** **Method:** ☐Open ☐Laparoscopic ☐Robotic
Gallbladder surgery?	☐Yes ☐No	When:
EGD (Upper Endoscopy)?	☐Yes ☐No	When:
Colonoscopy?	☐Yes ☐No	When:
Hernia Repair?	☐Yes ☐No	**When:** **Type:** **Method:** ☐Open ☐Laparoscopic ☐Robotic
Recently Hospitalized?	☐Yes ☐No	When:
Other:		When:
Other:		When:
Other:		When:
Other:		When:
Other:		When:
Other:		When:
Other:		When:

SOCIAL HISTORY		
Do you smoke?	☐Yes☐No ☐**Quit / When:**	How Often:
Do you drink alcohol?	☐Yes ☐No ☐**Quit / When:**	How Often:
Are you on dialysis?	☐Yes ☐No	

VITALS		
Your most recent or estimated:	**Height:**	**Weight:**

BELTLINE HEALTH
WEIGHT LOSS SOLUTIONS

MEDICATIONS & ALLERGIES | PHARMACY

Name:	**Date of Birth:** / /

MEDICATIONS			
Are you taking medications? ○ Yes ○ No			
Rx Name:	**Dosage:**	**How Often:**	**Reason:**

ALLERGIES			
Do you have any allergies? ○ Yes ○ No			
Allergy:		**Other Allergies:**	
☐ Penicillin	Reaction:	Other:	Reaction:
☐ Lidocaine	Reaction:	Other:	Reaction:
☐ Iodine Dye	Reaction:	Other:	Reaction:
☐ Sulfa	Reaction:	Other:	Reaction:
☐ Latex	Reaction:	Other:	Reaction:
☐ Codeine	Reaction:	Other:	Reaction:

PHARMACY INFORMATION	
Name:	**Phone #:**
Address:	

BELTLINE HEALTH
WEIGHT LOSS SOLUTIONS

SLEEP STUDY QUESTIONNAIRE | LAB TESTING | WOMEN'S HEALTH

Name:	**Date of Birth:** / /

SLEEP STUDY QUESTIONNAIRE (STOP BANG)		
Questionnaire required if you are considering bariatric surgery		
Your physician will determine if a sleep study is required prior to having bariatric surgery. This will be discussed at your appointment with your physician.		
S	**Have you been told you snore? (excessive snoring)**	○Y ○N
T	**Are you abnormally tired during the day? (excessive daytime fatigue)**	○Y ○N
O	**Do you know if you stop breathing or has anybody witnessed you stop breathing while asleep?**	○Y ○N
P	**Do you have high blood pressure or are you on medication to control high blood pressure?**	○Y ○N
B	**Is your body mass index greater than 28?**	○Y ○N
A	**Are you 50 years old or older?**	○Y ○N
N	**Is your neck circumference greater than (male) 17 in., or (female) 16 in.?**	○Y ○N
G	**Are you a male?**	○Y ○N

LAB TESTING FACILITY	
All labs must be sent to a 3rd party facility for processing. Beltline Health is not liable for financial balances due to uncovered labs through your insurance or self pay costs incurred. Please ensure your preferred facility is in-network with your insurance and you have reviewed the covered benefits of your plan.	
I prefer to have my labs sent to: ☐Quest / ☐Labcorp	**SIGN:**

WOMEN'S HEALTH	
Last menstrual cycle:	Are you pregnant? ☐Yes ☐No

BELTLINE HEALTH
WEIGHT LOSS SOLUTIONS

FINANCIAL POLICY

Our staff is concerned with the cost associated with your healthcare and considerable care has been taken in the establishment of our fee schedule. We assure you our charges accurately reflect the complexity of care rendered.

OFFICE FEES			
	SERVICE/CHARGE	**FEE**	**REQUIREMENTS**
	FMLA / Disability Paperwork / Documents required by a third party	$25.00 (initial) $15.00 (additional)	• Due at the time of the request • **Processing Time: 3-7 business days**
	Medical Records Request	$15.00	• Due at the time of the request • Processing Time: 7-14 business days
INITIAL _____	**Late Cancellation / No Show Policy (Office Visits)**	$30.00	• **24-Business Hours Notice Required** • Due before rescheduling
	Late Cancellation / No Show Policy (General Surgery)	$150.00	• **7-Days Notice Required** • Due before rescheduling • Hernia, Gallbladder, Endoscopy, etc.
	Late Cancellation / No Show Policy (Bariatric Surgery)	$400.00	• **14-Days Notice Required** • Due before rescheduling • Sleeve, Bypass, Duodenal Switch, Revision, etc.
	Returned Check	$12.00	• Due before the next appointment

PAYMENTS & CLAIMS	
	• All services will be filed with your insurance carrier except for the above listed services/charges. • Medical services not covered by your insurance plan will become your financial responsibility. • Required referrals that are not received prior to your visit will become your financial responsibility.
INITIAL _____	• Payment for all office appointments are due at the time of service. • Failure to pay at the time of service will require that your appointment is rescheduled for a later date.
	• **Verification of your benefits and preauthorization of your surgery is not a guarantee of payment.** • If your insurance denies your preauthorization or claim, it will become your financial responsibility. • **We encourage you to contact your insurance to obtain benefits, and exclusions on your policy.** • **Bariatric consultations are not a guarantee of bariatric coverage through your insurance. Payments for services rendered (insurance and self pay) are non-refundable unless paid by your insurance.**
	• Surgery estimates provided by our office are **solely for the physician's fee.** • **Hospital and other fees are separate** and are only provided by the hospital financial department.

SURGICAL ASSISTANT SERVICE	
	• All surgeries require an Assistant to ensure quality care and a safe operation. Endoscopies are excluded.
INITIAL _____	• The Surgical Assistant fee **IS NOT** included in or a part of the Surgeon's fee or hospital charges. • Your **insurance may not cover** this service and, if denied, it will become your financial responsibility. • The Surgical Assistant fee can range from $250 - $450.
	• **Medicare does not cover** surgical assistant services.
	• You authorize release of your protected personal medical records to process claims for this service.
	• If received, you agree to deposit your insurance check (paid to you for this service) into your account and pay Beltline Bariatric and Surgical Group for the same amount that the insurance check was for.

Signature:	**Printed Name:**	**Date:**

BELTLINE HEALTH
WEIGHT LOSS SOLUTIONS

RECORDS RELEASE | MEDIA RELEASE

Name:	**Date of Birth:** / /

I authorize Beltline Bariatric and Surgical Group to disclose my medical records to the authorized individuals:

DISCLOSURE TERMS	
○ **RELEASE** ○ **DECLINE**	**RECORDS DATING FROM:** / / **to** / /

AUTHORIZED PHYSICIANS		
1	**Name:**	**Phone:**
		Fax:
		Address:
2	**Name:**	**Phone:**
		Fax:
		Address:

AUTHORIZED FAMILY / FRIENDS / ETC.		
1	**Name:**	**Relationship:**
		Phone:
		Address:
2	**Name:**	**Relationship:**
		Phone:
		Address:

I understand that I have a right to revoke this authorization at any time in writing. I understand that this authorization is voluntary, and that I do not need to sign this form in order to receive treatment. I understand that if the organization/persons authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

Signature:	**Printed Name:**	**Date:**

MEDIA RELEASE
U.S. Federal law guarantees a patient's right to maintain privacy of medical information. Photographs are required as part of the patient's chart for the medical management of the patient.

I authorize Beltline Bariatric and Surgical Group to use my photographs/videos on the following marked platforms:

☐ I DECLINE ALL PLATFORMS *(excludes the patient's chart)*	☐ PRIVATE FACEBOOK GROUP	☐ GENERAL SOCIAL MEDIA
	☐ TV ADVERTISEMENT	☐ PRINT MARKETING

Signature:	**Printed Name:**	**Date:**

BELTLINE HEALTH
WEIGHT LOSS SOLUTIONS

INFORMED CONSENT

IN-OFFICE CARE		
	SERVICE	**DETAILS**
INITIAL _____	**Blood Draw**	This routine procedure may be performed by physicians, nurses, physician assistants, or medical assistants. There may be material risks. In rare circumstances, these routine procedures may cause infections, loss of limb or function, damage to tissue or implants, paralysis or death. I consent to the retention by the practice of the specimen removed for the purpose of laboratory testing and analysis either by the practice or a third-party testing facility.
INITIAL _____	**Injections and Shots**	This routine procedure may be performed by physicians, nurses, physician assistants, or medical assistants. There may be material risks. In rare circumstances, these routine procedures may cause nerve damage, infection, infiltration, disfiguring scar, loss of limb function, paralysis or death. Other side effects may include a warm sensation at the injection site, a sense of being swollen, headache and joint pain.
INITIAL _____	**Physical Assessments and Treatments**	This routine procedure may be performed by physicians, nurses, or physician assistants. This may include, but is not limited to, wound dressings, lap band adjustments, vital signs, and other similar procedures. There may be material risks. In rare circumstances, these routine procedures may cause infections, loss of limb or function, loss of blood, internal injury, nerve damage, disfiguring scar, damage to tissue or implants, paralysis or death.
INITIAL _____	**Transnasal Endoscopy**	This procedure may be performed by a physician with the assistance of a nurse, physician assistant, medical assistant, or medical staff. There may be material risks. In rare circumstances, these routine procedures may cause infection, pain, allergic reaction, disfiguring scar, loss of blood, loss of limb or organ function, paralysis, paraplegia or quadriplegia, brain damage, cardiac arrest, or death. This procedure may be performed with the administration of local anesthetics under the supervision of the physician or designated assistants. The risk of anesthetics may include heart attack and cessation of breathing. I consent to retention by the practice of the specimen removed for the purpose of laboratory testing and analysis either by the practice or a third-party testing facility. I consent to the photography, audio-visual recording and/or televising of the procedure, including appropriate portions of my body, to be used for medical, educational, or scientific purposes, or other reasons of my choice. This procedure may require the use of disposable and non-disposable equipment and instrumentation that may be reprocessed by a third-party vendor as required by the FDA.
INITIAL _____	**Medications**	I am responsible for notifying the Physician about medicines or supplements that I am taking that are prescribed by another provider. I am also responsible for notifying the Physician of any concerns or reactions to medications prescribed by our practice.
INITIAL _____	**Bariatric Supplements**	I understand that having bariatric surgery requires that I take the recommended bariatric supplements as described by the ASMBS guidelines and instructed by our practice. I understand that bariatric-specific supplements may be required for life or otherwise instructed by our practice.

TELEMEDICINE SERVICES	
INITIAL _____	• Applicable for patient-scheduled appointments only. This appointment will not be made without the patient being made aware and agreeing to this method of communication. • Please ensure you are in an environment you feel comfortable discussing personal medical information. We are not liable for any information given that has been exposed to those around you during this time. • If we are unable to connect to the video portion of the visit due to low connectivity, we will conduct your visit over the phone. This may result in a delay of treatment. • This video is a secure video call (Zoom, Facetime, or any other non-compliant platform will not be used for treatment). There may be circumstances when the video is recorded and uploaded to your secure, HIPAA-compliant patient record. • In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information. • In some instances, you may receive the Televisit link via SMS message. I am aware data/messaging rates may apply. I am responsible for any charges required of my carrier.

Signature:	**Printed Name:**	**Date:**