DFW Bariatric Institute - Medical Packet
(email to info@DFWBI.com or fax to 817-581-6127)

PATIENT INFORMATION

Last name:	First:	Maiden Name:

SSN:	Ethnicity:	D.O.B:	Age: Sex:M F

Home Phone #:	Cell Phone #:	Work Phone #:

May we leave message? Yes No	Where should we call? Home Cell Work
Can we email? Yes No	Email:

Street address: City: State: ZIP:

Occupation: Employer: Type:full time part time

Family Physician: Referring Physician: Cardiologist: Psychologist:

Best time to reach you? Time: Day of the week:

Pharmacy:	Telephone Number:

INSURANCE INFORMATION – WE WILL NEED A PHOTO OR COPY OF YOUR INSURANCE CARD EMAILED TO INFO@DFWBI.COM

Primary Ins.: ID#: Group#:

Ins. Phone #: Ins. Address:

Policy Holder Name & DOB:	Employer:	Employer address:	Employer phone #: ( )

Secondary Ins.: ID#: Group#:

Ins. Phone #: Ins. Address:

Policy Holder Name & DOB:	Employer:	Employer address:	Employer phone #: ( )

IN CASE OF EMERGENCY

Name: Relationship: Home phone #:( ) Work phone #:( )

Assignment of Insurance Benefits and/or Release of Medical Information: is authorized to my insurance company. The undersigned hereby authorizes DFW Bariatric Institute, RCPS, Inc, and Westwing Physicians to furnish all information to said companies and/or payers identified above that may be necessary for the completion of my medical claims. Payment of insurance claims are hereby assigned to these companies for application on the patient's bill. The undersigned and/or patient will be responsible for charges not covered by this assignment and/or not paid by said payers. Release of information, assignment of insurance benefits and the right to appeal, and direct payment are also authorized to the listed providers who render care to myself or my dependents.

Signature of Patient or Parent if Minor | Date

I attest that this information is true, accurate and complete to the best of my knowledge

Authorization for Use and Disclosure of Protected Health Information (PHI)
DFW Bariatric Institute
Phone 817-581-6100 Fax 817-581-6127

Last name: First: Telephone #:	Date of Birth:	SSN#:

Street address: City: State: ZIP Code:

I authorize	(Patient's physician) or Facility

to disclose my medical record information and / or protected health information for the purpose of Bariatric Surgery to:

DFW Bariatric Institute
5204 Colleyville Blvd
Colleyville, Texas 76034
Phone 817-581-6100 Fax 817-581-6127

I authorize DFW Bariatric Institute and associates to disclose my medical record information and / or protected health information to:

(Identify your insurance Company):

Type of access requested:

1. Letter of Medical Necessity and medical clearance for surgery
2. Progress Notes:
3. Lab Work
4. Weight history (one progress note per year x5 years of documented weight)
5. Medication Record
6. Operative Report
7. Band Flow Sheet
8. Other:

_____ I acknowledge, and hereby consent to such, that the released information may contain
(Initials) alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information.

I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it.
The information used or disclosed pursuant to the authorization maybe subject to re-disclosure by the recipient and no longer protected. I understand that the condition for release is not based on payment for treatment and care, enrollment or eligibility or whether I sign the authorization.
Fees/charges will comply with all laws and regulations applicable to release of information.
I have read the above and authorize the disclosure of the protected health information as stated.

____ ______________________

Signature of Patient or Parent if Minor Date

I attest that this information is true, accurate and complete to the best of my knowledge

PATIENT HISTORY QUESTIONNAIRE

Last name: First: Birth date: Age: Height: Weight: BMI:

Reason for seeing the doctor? Do you know which surgery you are interested in?	
Please list all prior surgeries:	
I agree to a blood transfusion in an emergency situation Do you currently have an abdominal / incisional hernia? Yes No Do you take any blood thinning medications such as Coumadin, warfarin, aspirin, or Plavix? Yes No	Tape Allergies? Yes No Latex Allergies? Yes No Do take any NSAIDS such as Ibuprofen, Motrin, Aleve, Celebrex or Naprosyn? Yes No

I use tobacco(including smoke, dip, chew, nicotine gum/patches): How Often: How Many Years: When Did You Quit:

I drink alcohol: How Often: How Many Years: When Did You Quit:

I use recreational Drugs: How Often: How Many Years: When Did You Quit:

I use Birth Control: Pills Condoms Tubal Ligation Other:

Do you have or use any of the following:

HYPERTENSION (HIGH BLOOD PRESSURE)
DIABETES MELLITUS
SLEEP APNEA - CPAP or BI PAP
HEART DISEASE
LUNG DISEASE (COPD/Emphysema) - Home Oxygen
PULMONARY EMBOLISM
SHORTNESS OF BREATH AND EXERCISE INTOLERANCE DUE TO OBESITY
ASTHMA
BLOOD CLOTS
BLOOD TRANSFUSION
LIVER DISEASE (Hepatitis B, Hepatitis C)
HIV/ AIDS
KIDNEY DISEASE - Dialysis
THYROID PROBLEMS
LUPUS
OTHER:

HEARTBURN/REFLUX
INDIGESTION / DYSPEPSIA
PROBLEMS SWALLOWING / EXCESSIVE CLEARING OF THROAT
ACID METALLIC TASTE IN MOUTH / SOUR STOMACH
COUGHING / HOARSENESS
VOMITING OR REGURGITATION WHEN LYING DOWN
FOOD GETS STUCK IN YOUR THROAT
GASSINESS / BLOATING
STOMACH ULCER
COLITIS
CROHN'S DISEASE/ ULCERATIVE COLITIS
HYPERCHOLESTEROLEMIA (ELEVATED CHOLESTEROL)
HYPERTRIGLYCERIDEMIA (ELEVATED TRIGLYCERIDES)
URINARY STRESS INCONTINENCE (WEAK BLADDER)
CHRONIC BACK AND JOINT PAIN
ARTHRITIS
MIGRAINE HEADACHES
EDEMA (LEG SWELLING)
DEPRESSION / BIPOLAR DISORDER/ANXIETY
FREQUENT PREDNISONE USE
FAMILY HISTORY: OBESITY, DIABETES, HYPERTENSION, HEART DISEASE, CANCER

Signature of Patient or Parent if Minor | Date

I attest that this information is true, accurate and complete to the best of my knowledge

MEDICATIONS AND PHYSICIANS

Last name: First: D.O.B.:

Medication Allergies? Yes No If Yes, please list:

Please list ALL medications you are currently taking: this includes over-the-counter products, prescription medications and any herbal supplements/vitamins you use.

Name:	Dose/Frequency:	#Pills/Refill:	Reason:	Date	Date	Date

Please list doctors you are currently seeing (including PCP, heart doctor, psychiatrist, therapist, dietitian, etc); if you do not know the address (including ZIP code), please call them to obtain a complete address.

Name:	Specialty:	Phone:	Fax:	Mailing Address:

Signature of Patient or Parent if Minor

I attest that this information is true, accurate and complete to the best of my knowledge

Date

WEIGHT RELATED HISTORY					
Last name: First: D.O.B.:					
Weight History – Please list your average weight over the last 5 years					
Year:	Age:	Weight:	Year:	Age:	Weight:

Supervised Weight Loss Attempts – Please check all of the weight loss efforts you have tried			
Home Gym Equipment Gym Membership Health Spa Calorie Counting High Protein Low Carb Low Fat Hypnosis	Atkins Diet Mayo Clinic Diet Richard Simons Scarsdale Diet Sugar Busters Slim Fast South Beach Diet	Acupuncture Diet Pills from MD Diet Shots from MD Diet Center Jenny Craig Overeaters Anonymous Optifast / Medifast	LA Weight Loss Nutri System Psychological Counseling Supervised Calorie Counting T.O.P.S. Weight Watchers Harris Fast

Check Each Medication you have tried:			
Acutrim OTC Adipex Amphetamines Dexatrim OTC	Fastin Herbal Remedies OTC Ionamin Meridia	Metabolife OTC Phentermine Pondimin Phen fen Duration:	Redux Tenuate Trimspa OTC Xenical Zenadrine OTC

Level of Activity:			
Activity: Aerobics-Land	Duration:	Frequency:	Limitations: Shortness of breath/pain
Aerobics-Water			
Biking			
Organized Exercise			
Stairs			
Swimming			
Walking			
Do you use any of these walking aids daily? Cane Walker Wheelchair Motorized Cart			

EMOTIONAL / PSYCHOLOGICAL EVALUATION
Last name: First: D.O.B.:
Please use the scale below to describe to what degree the problems listed below have BOTHERED or DISTRESSED you during the past week, including today.
Not at All 0 A Little Bit 1 Moderately 2 Quite a Bit 3 Extremely 4

_____ Nervousness or shakiness inside
_____ Unwanted thoughts, words, or ideas that won't leave your mind
_____ The idea that someone else can control your thoughts
_____ Feeling others are to blame for most of your troubles
_____ Trouble remembering things
_____ Feeling easily annoyed or irritated
_____ Feeling afraid in open spaces or in the street
_____ Thought of ending your life
_____ Hearing voices that other people do not hear
_____ Feeling that most people cannot be trusted
_____ Crying easily
_____ Feeling of being trapped or caught
_____ Suddenly scared for no reason
_____ Temper outbursts that you could not control
_____ Feeling afraid to go out of your house alone
_____ Feeling blue
_____ Worrying too much about things
_____ Feeling fearful
_____ Other people being aware of your private thoughts
_____ Having to avoid certain things, places, or activities because they frighten you
_____ Your mind going blank
_____ Feeling hopeless about the future
_____ Trouble concentrating
_____ Having thoughts that are not your own
_____ Having urges to beat, injure, or harm someone
_____ Having urges to break or smash things
_____ Having ideas or beliefs that others do not share
_____ Spells of terror or panic
_____ Getting into frequent arguments
_____ Feeling nervous when you are left alone
_____ Feeling so restless you couldn't sit still
_____ Feelings of worthlessness
_____ Feeling that familiar things are strange or unreal
_____ Shouting or throwing things
_____ Thoughts of suicide
_____ The idea that you should be punished for your sins
_____ The idea that something is wrong with your mind
_____ Feeling afraid to travel on buses, subways or trains

WHAT YOU HOPE TO ACHIEVE
Last name: First: D.O.B.:
In your own words, please describe what you hope to accomplish and how you believe your life will change by losing weight:

Sleep Habit/ Epworth Scale

Name: ____ DOB: __________________________

Height: _______________ Weight: ___________________

Do you have or have you had trouble sleeping? € Yes € No

If yes, what symptoms do you experience?

Morning Headaches?	€ Yes	€ No
Snoring?	€ Yes	€ No
Waking up at night?	€ Yes	€ No
Insomnia?	€ Yes	€ No
Daytime Drowsiness?	€ Yes	€ No
Restless sleep?	€ Yes	€ No
High blood pressure?	€ Yes	€ No
Anxiety?	€ Yes	€ No
Depression?	€ Yes	€ No

Leg Movements during sleep?
€ Yes € No

Narcolepsy-Daytime sleep attacks?
€ Yes € No

Restless legs just prior to or while falling asleep?
€ Yes € No

Number of Naps a Day: ____

Do you clinch or grind your teeth?	€ Yes	€ No
Do you feel rested when you wake up in the morning?	€ Yes	€ No
Have you ever fallen asleep at the wheel?	€ Yes	€ No
Falling asleep at inappropriate times?	€ Yes	€ No
Do you ever wake up from a deep sleep choking and coughing?	€ Yes	€ No
Has anyone ever told you that you stopped breathing while you sleep (an observed apnea)?	€ Yes	€ No

If Yes, how often does this occur: ____

Have you ever had a sleep study? €Yes €No Date: _______

Did you have sleep apnea? €Yes €No

If you have sleep apnea do you use: €CPAP €BiPAP

Please indicate the chance of dozing in each situation using the scale:

0= no chance of dozing
1= slight chance of dozing
2= moderate chance of dozing

Situation	Chances of Dozing
Sitting and reading	___________________________
Watching Television	___________________________
Sitting inactive in a public place (e.g. a theater or meeting)	___________________________
As a passenger in a car for an hour without a break	___________________________
Lying down to rest in the afternoon when circumstances permit	___________________________
Sitting and talking to someone	___________________________
Sitting quietly after lunch without alcohol	___________________________
In a car, while stopped for a few minutes	___________________________
Total Score:	___________________________

Overall, how long have you been experiencing these symptoms? ________ years / months / days

____ ______________________

Signature of Patient or Parent if Minor **Date**

I attest that this information is true, accurate and complete to the best of my knowledge

DFW Bariatric Institute

Dear Patient,

Please read this, initial each item, and sign below indicating that you understand the guidelines.

APPOINTMENT

- If you find that you are unable to keep your appointment, please call to cancel 24 hours in advance so that a time will be available for other patients.
- If you are more than 10 minutes late to your appointment, you may be asked to reschedule.
- **There will be a $25.00 charge if 24 hours notice is not given for cancellations.**

Initials ______

INSURANCE AND FEES

- I agree to pay for any and all medical services I receive from the doctor/providers of this practice that my insurance company refuses to pay, for whatever reason. This office will file a claim in my behalf, however, if my insurance company refuses to pay, for whatever reason (e.g., non-covered services, plan does not pay for preventive medicine visits or my failure to secure a referral from my primary care physician) I will pay for the visit upon written/verbal notice of their refusal. Failure to pay within 45 days of filing is, for the purpose of this agreement, a refusal to pay.
- There is a $20.00 fee per form that must be paid in advance before we complete and/or return the form for Disability Insurance forms, Leave of Absence forms, and/or Return to work forms.

Initials ______

ACCOUNT BALANCES AND RETURNED BANK ITEMS

- Our office staff will always be glad to discuss fees with you. Should you have financial problems that result in the delay of payment, please contact the office manager and discuss the situation. We will not know you are having problems unless you tell us. We will make every effort to work out an acceptable payment plan to enable you to take care of your obligation.
- Patient account balances that exceed 60 days without payment will be turned over to our collection agency.
- We accept Cash, Check, Visa, MasterCard, and Care Credit or Money orders.
- If your check is returned from the bank, we will add the "returned fee" to your account in the amount of $30.00.

Initials ______

CHILD POLICY

- We consider ourselves a family friendly business and welcome the support that your family can provide to you during your weight loss journey. However out of respect for fellow patients, the safety of your children and productivity of our staff we kindly ask that no children under the age of 17 accompany you to the back for your appointment. Further, children under the age of 17 may not be left unattended in the waiting area.
- Children are not allowed in classes.

Initials ______

I have read, understand, and agree to all of the above statements. I understand the charges not covered by my insurance, as well as applicable co-payment and deductible are my responsibility.

______________________________ ____________________

Patient Signature Date

DFW Bariatric Institute

Patient Consent for Use of Email Communications

To better serve our patients, this office has established an email address for some forms of communication. For routine matters that do not require immediate response, please feel free to contact us at appointments@DFWBI.com. Please remember however, that this form of communication is not appropriate for use in an emergency. The turnaround time for routine patient communications is 24 hours. The service provider may delay message delivery. **Should you require urgent or immediate attention, this medium is not appropriate**.

When sending emails please put the subject of your message in the subject line, so we can process it more efficiently. Also make sure to put your name, date of birth and return telephone number in the body of the message. We also ask that you acknowledge receipt of emails coming from this office by using the auto reply feature. Communications relating to diagnosis and treatment will be filed in your medical record.

This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of email, third parties may have access to messages. When communicating from work, you should be aware that some companies consider email corporate property and your messages may be monitored. Even when emailing from home, you may feel that access to your email is not well controlled, so you should take that into consideration. In addition, you should be aware that, although addressed to me, my staff and/or colleagues would have access to this information.

I understand that this office will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond this office's control. I understand and agree to the above email policy. By signing below, you are agreeing that we may send medical related correspondence to you via email, and that we may respond to your emails to us via email.

________________________________ Date:______________________

Patient signature

Physician Assistant Consent Form

This facility has on staff a Physician Assistant to assist in the delivery of medical care. A Physician Assistant is not a doctor. A Physician Assistant is a graduate of a certified training program and is licensed by the state board. Under the supervision of a Physician, a Physician Assistant can diagnose, treat, and monitor acute and chronic diseases as well as provide health maintenance care. Supervision does not require the constant physical presence of the supervising physician, rather the overseeing of activities of and accepting responsibility for the medical services provided. A Physician Assistant may provide such medical services that are within his/her education, training, and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulating a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Offering counseling and education
- Supplying sample medications and writing prescriptions
- Making appropriate referrals

I _______________________________________ have read the above, and hereby consent to the services of a Physician Assistant for my health care needs. I understand that at any time I can refuse to see the Physician Assistant and request to see a Physician.

________________________________ Date: _______________________

Patient signature

DFW Bariatric Institute Authorization

DFW Bariatric Institute loves to share the success stories of our patients with others, to help them make the decision to start their weight loss journey. We believe interaction of our patients is one of the most valuable forms of research and we support and encourage this through multiple mediums. Please indicate below in what ways you would like to participate in this process.

I (Printed Name) ____ authorize DFW Bariatric Institute to use and disclose my information to include:

- Health related issues that resulted in my decision to have bariatric surgery
- Details of my bariatric surgery
- Interviews you provide and their transcripts
- Your image

Indicate the ways you would like to participate by placing your initials below:

______ DFWBI.com & DrDKim.net web site

______ DFW Bariatric Institute Social Media, consisting of, but not limited to Facebook, Twitter, Instagram, Pinterest, YouTube, LinkedIn and Google Plus.

______ Creation and distribution of DFW Bariatric Institute Television Commercials, Billboards and Radio spots.

______ Creation and distribution of Television programs featuring DFW Bariatric Institute.

______ Creation and distribution of Radio programs featuring DFW Bariatric Institute.

______ Creation and distribution of Videos to be presented in DFW Bariatric Institute waiting rooms.

DFW Bariatric Institute will be working with several companies that support their marketing activities to share your story. These companies consist of, but are not limited to Silvr Social, Rosemont Media, and United Media Group. You have the right to revoke this authorization by providing a written request to DFWBI, 5204 Colleyville Blvd, Colleyville, Texas 76034. In the event that you participate in a production and you sign a talent release, you will be held to the talent release agreement which is a separate contract. DFW Bariatric Institute cannot require the patient to sign this authorization in order to receive treatment. The information disclosed pursuant to the authorization may be redisclosed by recipients and no longer be protected by the federal privacy regulations. This authorization will expire if the below signed decides to terminate the practice, patient relationship with DFWBI.

Signature of Patient: ____ Date: _________________________

Note: If the patient's personal representative signs the authorization, the authorization also **must** include a description of that person's authority to act for the patient.

DFW Bariatric Institute

PERSONS WHO ARE AUTHORIZED TO RECEIVE INFORMATION:
HEALTH INFORMATION OUR OFFICE COLLECTS OR RECEIVES ABOUT YOU MAY BE DISCLOSED TO THE FOLLOWING PERSONS:

NAME: ____________________________________ RELATIONSHIP: ____________________

NAME: ____________________________________ RELATIONSHIP: ____________________

USE AND DISCLOSURE OF INFORMATION:

____
PLEASE INITIAL

I AUTHORIZE THE PERSON(S) LISTED ABOVE TO RECEIVE ALL HEALTH INFORMATION ABOUT APPOINTMENTS, TREATMENT AND/OR OTHER INFORMATION PERTINENT TO MY HEALTHCARE AND /OR PAYMENT FOR MY HEALTHCARE.

-- OR –

____
PLEASE INITIAL

I DO NOT AUTHORIZE ANY INFORMATION TO BE DISCLOSED TO ANY OTHER PARTIES EXCEPT TO ME AS THE PATIENT.

YOU MAY REVOKE OR TERMINATE THIS AUTHORIZATION BY SUBMITTING A WRITTEN REVOCATION TO OUR OFFICE TO ATTENTION OF THE PRIVACY OFFICIAL OR OTHER AUTHORIZED REPRESENTATIVE. HOVEVER, YOUR DECISION TO REVOKE THE AUTHORIZATION WILL NOT BE IN EFFECT OR UNDO ANY USE OF DISCLOSURE OF INFORMATION THAT OCCURRED BEFORE YOU NOTFIED US OF YOUR DECISION.

COMMENTS: ____
____

____
PLEASE INITIAL

I have received the information entitled
"Notice of Privacy Policies and Practices"

____ PRINT NAME
DOB

____ SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE
DATE

NOTICE OF PRIVACY POLICIES AND PRACTICES
For
DFW Bariatric Institute

DEAR PATIENT:

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

INTRODUCTION

At our practice, we are committed to treating and using protected health information about you responsibly. This Notice describes the personal information we collect and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003 and applies to all protected health information as defined by federal regulations.

UNDERSTANDING YOUR MEDICAL RECORD/HEALTH INFORMATION

Each time you visit our office, a record of your visit is made. Typically, this record contains information about your visit including your examination, diagnosis, test results, treatment as well as other pertinent healthcare data. This information, often referred to as your health or medical record, serves as a:

- **Basis for planning your care and treatment**
- **Means of communication with other health professionals involved in your care**
- **Legal document outlining and describing the care you received**
- **A tool that you, or another payer (your insurance company) will use to verify that services billed were actually provided**
- **An education tool for medical health providers**
- **Basis for public health officials who might use this information to assess and/or improve state as well as national healthcare standards**
- A tool that we can reference to ensure the highest quality of care and patient satisfaction

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, determine what entities have access to your health information, and make an informed decision when authorizing the disclosure of this information to other individuals.

YOUR RIGHTS

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information; must be in writing
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive a printed copy of this notice

OUR RESPONSIBILITIES

Our office is required to:

- Maintain the privacy of your health information
- We are required by law to provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction and acknowledge revisions with notifications
- Accommodate reasonable requests you may have regarding communication of health information via alternative means and/ locations

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Any updates will be posted in our office. We will not use or disclose your health information without your authorization, except as described in this notice.

HOW WE MAY USE AND/OR DISCLOSE YOUR HEALTH INFORMATION

PATIENT INFORMED CONSENT, MEDICAL & SURGICAL WEIGHT LOSS

We will use your health information for treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example: results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

We will use your information for payment. Your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated in order to pay for the service rendered to you.

We will use your information for regular health operations. Your health information may be used as necessary to support the day-to-day activities and management of NHFP. For example: information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality.

Business Associates. In some instances, we have contracted separate entities to provide services to us. These "associates" require your health information in order to accomplish the tasks that we ask them to provide. Some examples of these "business associates" might be a collection agency, answering service and computer software/hardware provider.

Communication with family. Due to the nature of our field, we will use our best judgment (ex: emergency situations) when disclosing health information to a family member, other relatives, or any other person that is involved in your care or that you have authorized to receive this information. We will ask patients 18 years and older to sign a consent to release information to anyone other than themselves.

Healthcare Oversight. Federal law requires us to release your information to an appropriate health oversight agency, public health authority or attorney, or other federal/state appointee if there are circumstances that require us to do so.

Public health reporting. Your health information may be disclosed to public health agencies as required by law.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Appointment reminders. This practice may use your information to remind you about upcoming appointments. Typically, appointment reminders are sent by mail or a brief, non-specific message may be left on your answering machine / voicemail.

Other uses and disclosures. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have complaints, questions or would like additional information regarding this notice or the privacy practices of DFW Bariatric Institute please contact:

PRIVACY OFFICE
5204 Colleyville
Colleyville, TX 76034
817-581-6100

If you believe that your privacy rights have been violated, please contact the aforementioned practice Privacy Official, or, you may file a complaint with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the practice's Privacy Official or with the Office for Civil Rights. The address for the Office for Civil Rights is listed below:

OFFICE FOR CIVIL RIGHTS
U. S. Department of Health and Human Services

200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D. C. 20201

I. PROCEDURE AND ALTERNATIVES

a. I authorize the medical staff at DFW Bariatric Institute, to assist me in my weight loss efforts. I understand my treatment may involve the use of one or more of the following modalities to lose weight: a very low calorie diet (VLCD); use of appetite suppressants for more than 12 weeks, the time period indicated in the appetite suppressant labeling; off-label use of Metformin for treatment of obesity.

b. I understand it is my responsibility to follow the instructions carefully and to report to the doctor treating me for my weight any significant medical problems that I think might be related to my weight control program as soon as reasonably possible.

c. I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain the weight loss. I understand my continuing to receive the VLCD supplements, appetite suppressant or Metformin will be dependent on my progress in weight reduction and weight maintenance. I am aware that weight gain may occur if I am not compliant with the program.

d. I understand there are other ways and programs that can assist me in my desire to lose and maintain my weight.

II. RISKS OF PROPOSED TREATMENT

a. Prior to my treatment, I have fully disclosed any medical conditions or disease that may prevent me from receiving appetite suppressant or VLCD for my weight loss.

b. I understand this authorization is given with the knowledge that the use VLCDs and appetite suppressants may involve some increased risks and hazards such as the following:

i. Side effects of VLCDs: lightheadedness, fatigue, constipation, headache, bad breath, dry mouth, nausea/vomiting, diarrhea and hair loss. Less likely are gallbladder disease, allergy, fainting, low potassium and low sodium. In addition, the use of a VLCD with blood pressure and/or diabetes medications could cause low blood pressure and/or low blood sugar, respectively. These and other possible risks could, on a rare occasion, be serious or fatal.

ii. Side effects of appetite suppressants: nervousness, insomnia, headaches, dry mouth, diarrhea, constipation, nausea/vomiting, psychological problems, medication allergies, high blood pressure, rapid heartbeat and heart irregularities. Although rarely, it can lead to pulmonary hypertension. These and other possible risks can be fatal on a rare occasion.

iii. Side effects of Metformin: diarrhea, nausea/vomiting, bloatedness, weakness, indigestion, abdominal discomfort, headache and hypoglycemia. Less likely are signs of lactic acidosis, including feeling tired or weak, muscle pain, trouble breathing, stomach pain, feeling cold, dizziness or lightheadedness, and a slow or irregular heartbeat. These and other possible risks could, on a rare occasion, be serious or fatal.

c. I understand that the use of appetite suppressant or Metformin is absolutely contraindicated during pregnancy and breastfeeding. I understand that it is my responsibility to inform the medical staff at DFW Bariatric Institute if I am pregnant, if I am trying to become pregnant or if I become pregnant during the course of these treatments.

d. I agree to immediately report any change in medical history/medication or problems that might occur to my medical provider during the treatment program.

III. RISKS ASSOCIATED WITH BEING OVERWEIGHT OR OBESE - I am aware that there are certain risks associated with remaining overweight or obese. Among them are tendencies to have high blood pressure, diabetes, back and joint pain, heart diseases, cancer and gallbladder disease. I understand the risks may be modest with weight reduction, but that these risks can go up significantly the more overweight I am.

IV. NO GUARANTEES - I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that I will have to continue with sensible and nutritional eating habits and regular exercise if I want long term success. I understand that many health insurances do not pay for my weight loss treatment. I acknowledge and agree to pay all charges and fees associated with my weight loss program if the fees are not covered by my health insurance.

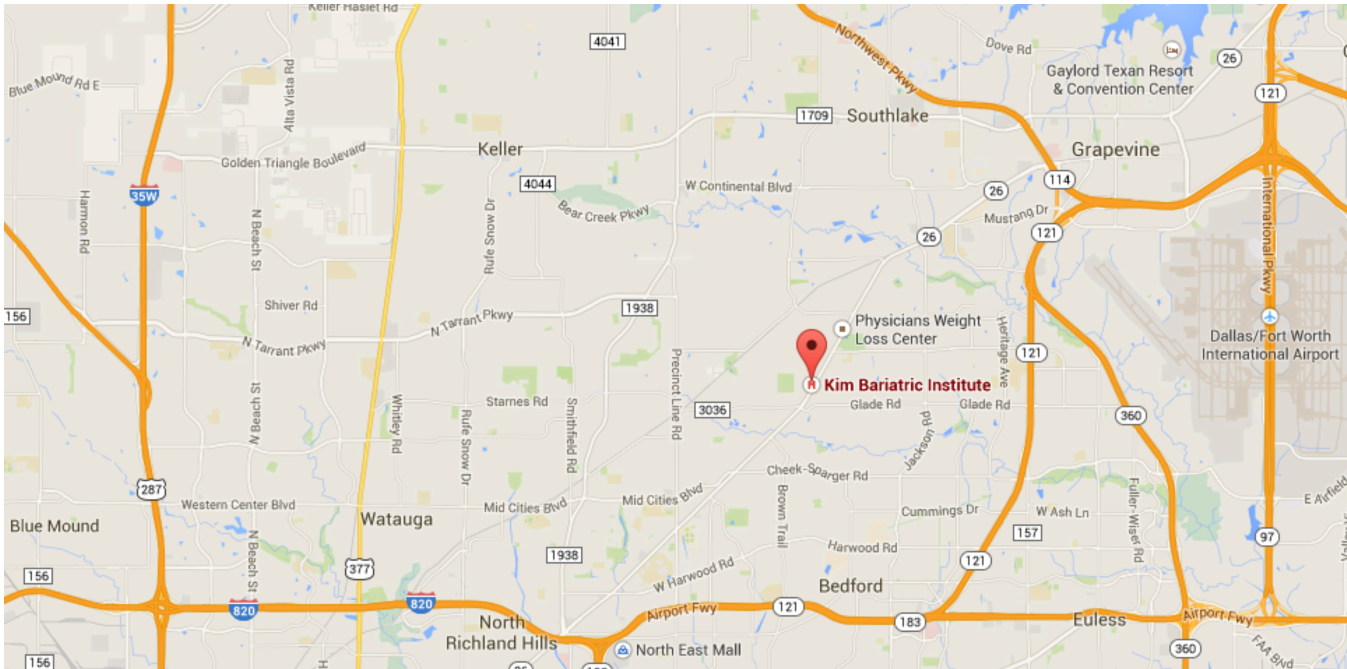
I, the undersigned, have reviewed this information with my healthcare professional or my physician, and have had an opportunity to ask questions and have them answered to my satisfaction.

Patient Signature: ____DATE:_____________________

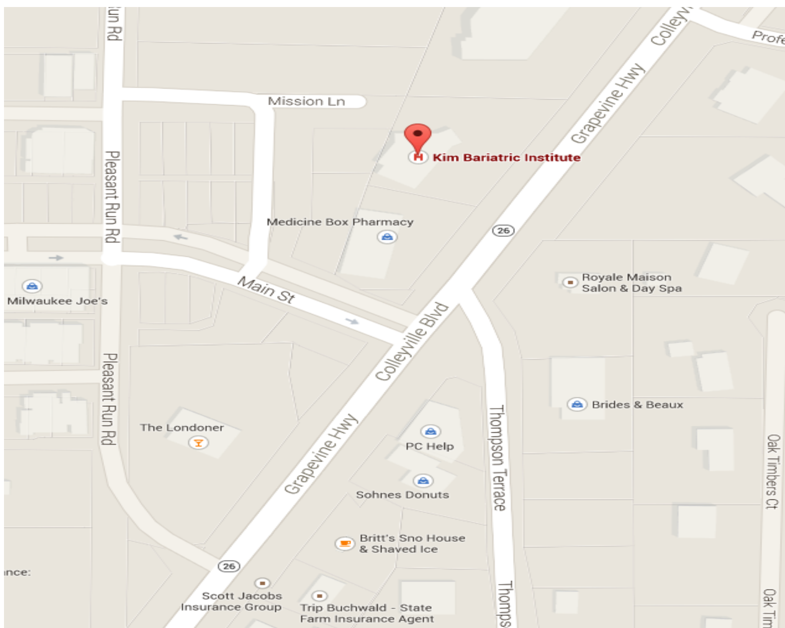
PA / Physician Signature: ____DATE:_____________________

DFW Bariatric Institute has a Colleyville. Frisco and a new Rockwall location, please make sure you know the correct location of your appointment.

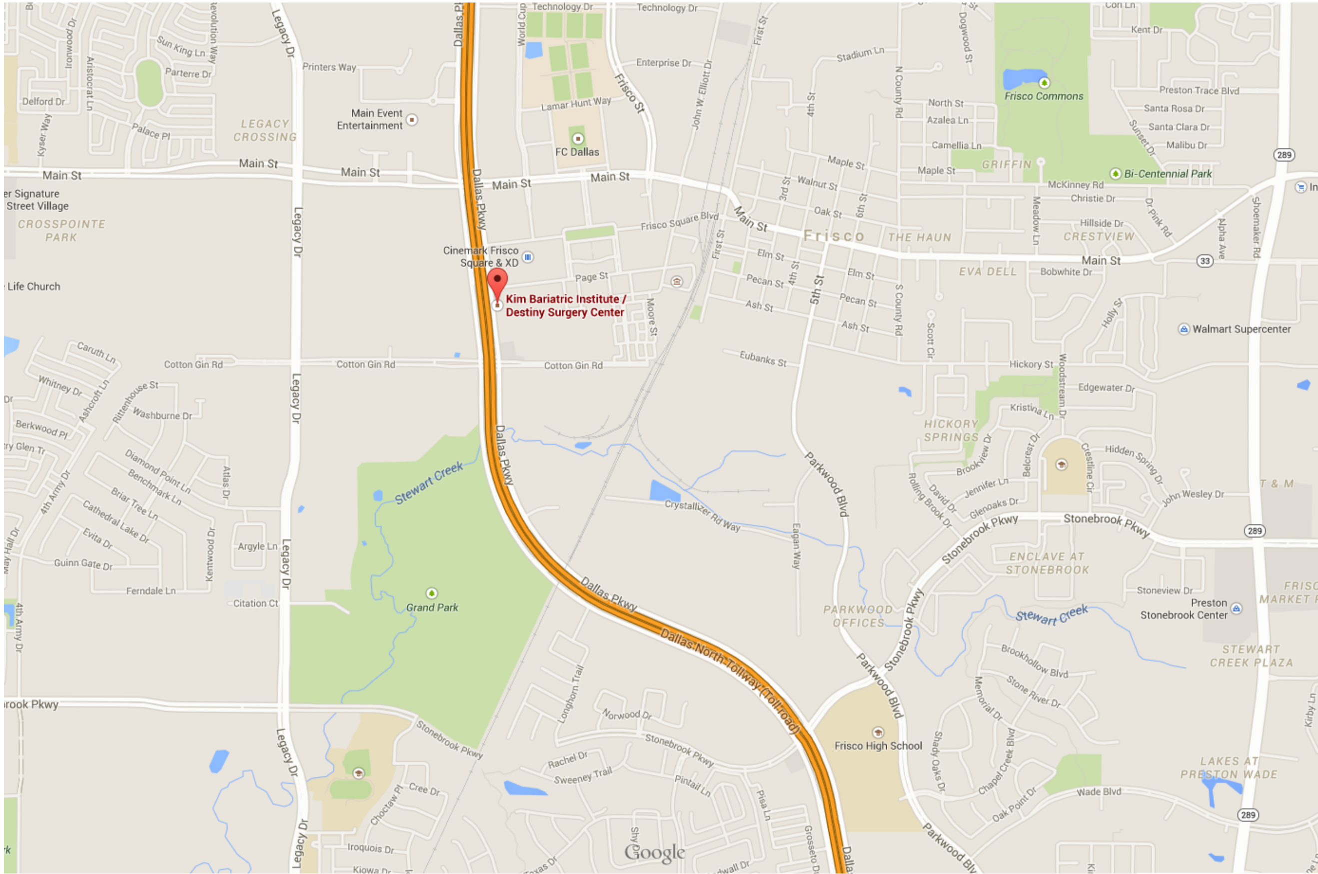
Colleyville Location - 5204 Colleyville Blvd, Colleyville TX



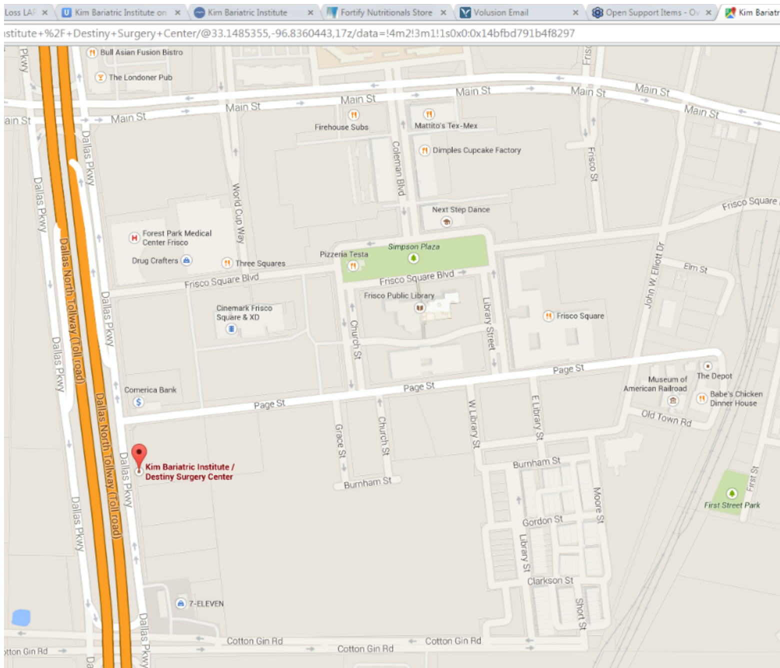
Detailed map of the immediate area surrounding DFW Bariatric Institute.



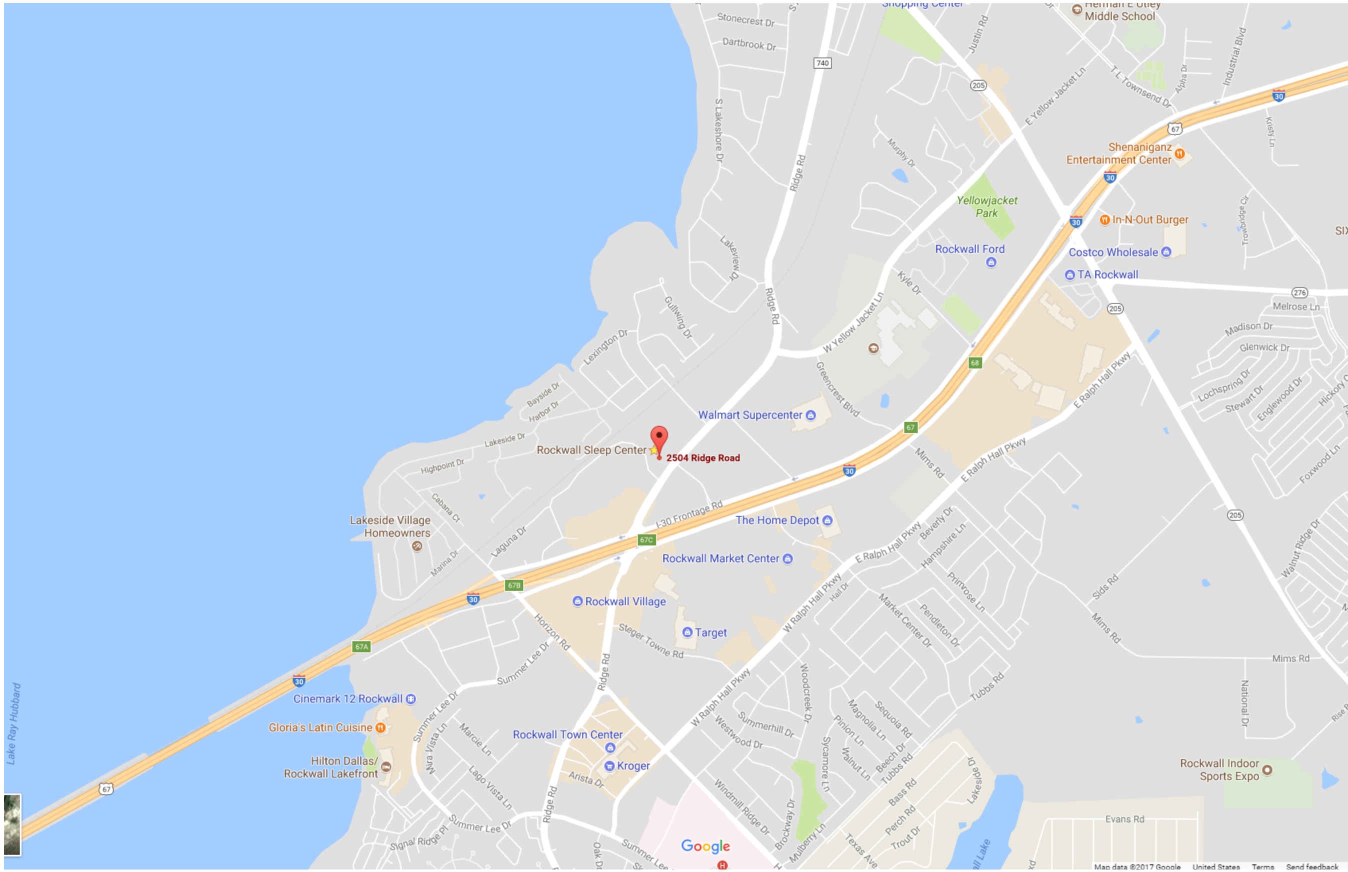
Frisco Location - 8350 Dallas Parkway, Frisco, TX



Detailed map of the immediate area surrounding DFW Bariatric Institute.



Rockwall Location – 2504 Ridge Road, Suite 104, Rockwall, TX 75087



Detailed map of immediate area surrounding DFW Bariatric Institute.