DFW Institute - Medical Packet
(email to info@DFWBI.com or fax to 415-795-4434)

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 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 Institute
Phone 817-581-6100 Fax 415-795-4434

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 Institute
10400 N. Central Expy
Dallas, Texas 75321
Phone 817-581-6100 Fax 415-795-4434

I authorize DFW 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**	Tape Allergies? ☐ Yes ☐ No Latex Allergies? ☐ Yes ☐ No Do take any NSAIDS such as Ibuprofen, Motrin, Aleve, Celebrex or Naprosyn? ☐ Yes ☐ No
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	

☐ 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 Date

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

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:

DFW Institute

Dear Patient,

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

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 $25.00 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 _____

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 financial responsibility.

_____ _____

Patient Signature Date

DFW 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 info@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 Institute Authorization

DFW 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 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 web site

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

☐ _____ Creation and distribution of DFW Institute Television Commercials, Billboards and Radio spots.

☐ _____ Creation and distribution of Television programs featuring DFW Institute.

☐ _____ Creation and distribution of Radio programs featuring DFW Institute.

☐ _____ Creation and distribution of Videos to be presented in DFW Institute waiting rooms.

DFW 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, 10400 N. Central Expressway Dallas Texas 75231. 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 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 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 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

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 Institute please contact:

PRIVACY OFFICE
10400 N. CENTRAL EXPY
Dallas, TX 75231
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

PATIENT INFORMED CONSENT, MEDICAL & SURGICAL WEIGHT LOSS

I. PROCEDURE AND ALTERNATIVES

a. I authorize the medical staff at DFW 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, bloating, 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 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:_____