

Patient's Name _____ Date of Birth _____

All charges are due at the time of service. If hospitalization or surgery is indicated, we will file your claim directly to your insurance company. Please remember that most insurance companies do not pay the full amount, and therefore, you are responsible for the balance. If there is a problem paying the balance in full, please let us know and we will be happy to work with you.

Insurance Information

Participating Insurance Companies - For those companies we participate with, Premier will file your claim for you and accept assignment for payment directly to us. Please provide us with current and valid insurance cards.

Non-Participating Insurance Companies – In those cases where we are non-par, Premier will file your insurance claim for you but will not accept assignment, meaning payment will be made directly to you. You are responsible for payment of your account in full so please plan to direct any payments to us.

Referrals and Authorizations – It is your responsibility to understand your benefit design and obtain all required referrals and authorization approvals from your insurance company. Failure to do so will result in reduced benefits and higher patient responsibility for you.

Other Payment Information

Office Visits – All co-pays, deductibles or co-insurance are due at the time of service.

Surgery – If surgery is required, you will be responsible for all or a portion of the fee, payable in the form of a deposit at the time of scheduling. If you are having non-urgent or elective surgery, 100% of the estimated patient responsibility portion will be due prior to scheduling the service. If you have a life threatening illness and need urgent or emergency care, we will not delay your surgery; however, non-urgent or elective surgeries may be delayed pending payment of your portion of the estimated fees. If you do not have insurance and need to discuss a payment plan, please notify us before we schedule your surgery.

Work's Compensation – You must contact your employer and their worker's compensation insurance company and be assigned a case worker before we will be able to treat you for a worker's compensation injury.

Payment Options / Billing Questions – Payment options include cash, check, MasterCard, and Visa. For billing questions or credit care payments, you may reach us at 865-306-5700. Payments may be mailed to Premier Surgical Associates, PO BOX 52948, Knoxville, TN 37950-2948

Interest and Fees – Balances not paid in full within 30 days are subject to interest at 18% APR. Balances that are turned over to collection agencies are assessed a 30% collection fee.

Returned Checks – If your check is returned for non-sufficient funds, you expressly authorize your account to be electronically debited or bank drafted for the amount of the check plus any applicable fees. The use of a check for payment is your acknowledgement and acceptance of this policy and its terms and conditions. A \$25.00 charge will be added to your account for each returned check. Additionally, you will not be able to schedule any follow-up appointments until the fee is paid in full.

Name: _____

PATIENT MEDICAL HISTORY

Date: _____

Reason for Visit: _____

DOB: _____

Age: _____

Height: _____

Weight: _____

Please Mark all that apply and if Applicable date of occurrence

ENDOCRINE

Current

Past

- Diabetes Type 1
- Diabetes Type 2
- Pre-Diabetic/Insulin Resistant
- Hypothyroidism
- Hyperthyroidism
- High Cholesterol

Recent Weight Gain _____ LBS

Recent Weight Loss _____ LBS

Fever – how high _____ ° F

SKIN/BREAST

C

P

- Breast Cancer
- Skin Cancer
- Scleroderma
- Brest Lump/mass
- Breast Pain
- Skin Lesions
- Skin Rash
- Skin Fold Irritation

ENMT

C

P

- Hearing Loss
- Bleeding Gums

HEMATOLOGIC/LYMPH

C

P

- Blood Clot
- Deep Vein Thrombosis
- Superficial blood clot
- Vena Cava Filter Placement
- Hemophilia A
- Carrier of Hemophilia A
- Hemophilia B
- Carrier Of Hemophilia B
- Iron Deficiency Anemia
- Anemia
- HIV infection
- AIDS
- Leukemia
- Non-Hodgkin’s Lymphoma
- Lymphoma
- Easy Bruising
- Swollen lymph Nodes

Location _____

EYES

C

P

- Glaucoma
- Blindness
- Eye Pain
- Visual Impairment
- Diabetic Retinopathy

GASTROINTESTINAL

C

P

- Gallstones
- Diverticulosis
- Diverticulitis
- Irritable Bowel
- Crohn’s Disease
- Ulcerative Colitis
- Colon Cancer
- Jaundice
- Hepatitis A
- Hepatitis B
- Hepatitis C
- Chronic Liver Disease
- Fatty Liver
- Cirrhosis
- Hiatal Hernia
- Internal Hernia
- Inguinal Hernia

Location _____

- Umbilical Hernia
- Incisional Hernia
- Ventral Hernia
- Reflux/GERD
- Heartburn
- Difficulty Swallowing
- Black/Tarry Stool
- Nausea
- Vomiting
- Constipation
- Diarrhea
- GI Infections
- Abdominal Pain

Location _____

Started _____

Provider Signature _____

Date _____

Name: _____

PATIENT MEDICAL HISTORY

Date: _____

GENITOURINARY	CURRENT	PAST
Receiving Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Start Date _____		
Chronic Renal Failure	<input type="checkbox"/>	<input type="checkbox"/>
Acute Renal Failure	<input type="checkbox"/>	<input type="checkbox"/>
End Stage Renal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>
Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>
Pain with Urination	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Voiding	<input type="checkbox"/>	<input type="checkbox"/>
Stress Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Benign Prostate Hypertrophy	<input type="checkbox"/>	<input type="checkbox"/>
Male Infertility	<input type="checkbox"/>	<input type="checkbox"/>
Polycystic Ovarian Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Female Infertility	<input type="checkbox"/>	<input type="checkbox"/>
Menorrhagia	<input type="checkbox"/>	<input type="checkbox"/>
Amenorrhea	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Length of Period	<input type="checkbox"/>	<input type="checkbox"/>
Possible Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>

CARDIOVASCULAR	C	P
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Start Date: _____		
Tachycardia	<input type="checkbox"/>	<input type="checkbox"/>
Rhythm Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Murmurs	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Placed _____		
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>
Limb Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Location: _____		
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Date: _____		
Peripheral Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>
Ischemic Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Peripheral Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>

SLEEP APNEA – Please Answer Yes	NO
Do you Have Sleep Apnea	<input type="checkbox"/>
Do you Use CPAP <input type="checkbox"/> Bipap <input type="checkbox"/> Other <input type="checkbox"/>	
Excessive/Loud Snoring	<input type="checkbox"/>
Daytime Sleepiness	<input type="checkbox"/>
Has someone observe you stop breathing while asleep	<input type="checkbox"/>

RESPIRATORY	CURRENT	PAST
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Pickwickian Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary Embolism	<input type="checkbox"/>	<input type="checkbox"/>
Date: _____		

MUSCULOSKELETAL	C	P
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Location: _____		
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>
Location: _____		
Difficulty Walking	<input type="checkbox"/>	<input type="checkbox"/>
Use of: Wheelchair <input type="checkbox"/> Walker <input type="checkbox"/> Cane <input type="checkbox"/>		
Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Lower Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Sciatica	<input type="checkbox"/>	<input type="checkbox"/>
Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Cramps	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>

NEUROLOGICAL	C	P
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Date: _____		
Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>
Date: _____		
Diabetic Neuropathy	<input type="checkbox"/>	<input type="checkbox"/>
Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Convulsive Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Pseudotumor Cerebri	<input type="checkbox"/>	<input type="checkbox"/>
Confusion	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>

MENTAL HEALTH	C	P
Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Personality Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>

Provider Signature _____

Date _____

Name: _____

PATIENT MEDICAL HISTORY

Date: _____

Date of Last Mammogram: _____

Date of Last Colonoscopy: _____

Have you had a DEXA or Bone Density Scan

YES; Date _____ NO

SOCIAL HISTORY

YES NO

Do you Drink Alcohol

How Frequently: _____

Do you Drink Caffeine

Do you use Illegal Drugs

Do you Smoke

Have you ever smoked

Do you use other Tobacco

FAMILY HISTORY

YES Relation

Heart Disease _____

Hypertension _____

Diabetes _____

Stroke _____

Cancer _____

Type and Family Member: _____

Surgical History: place date next any surgery you have had in the past.

ARTERIAL SURGICAL HISTORY DATE

AAA Repair _____

Previous Coronary Artery ByPass _____

ByPass Graft of Extremity _____

Location: _____

Stent Placement – Arm or Leg _____

Temporal Artery Biopsy _____

CARDIOVASCULAR SURGERIES DATE

Heart Valve Replacement _____

CABG – Heart ByPass _____

Pacemaker Placement _____

Cardioverter/Defibrillator _____

Cath Stent Placement _____

Lung Surgery _____

WEIGHT LOSS SURGERY DATE

Roux en Y Gastric By-pass _____

Distal ByPass _____

Adjustable Band _____

Sleeve Gastrectomy _____

LGCP _____

BPD with DS/ without DS (circle one_) _____

Revison/Converson to another procedure _____

HEAD AND NECK SURGERY

DATE

Thyroid Surgery _____

Parathyroid Surgery _____

Carotid Thromboendarterectomy _____

Tonsillectomy/Adenoidectomy _____

Cataract Surgery _____

Craniotomy _____

FEMALE SURGERY DATE

Breast Surgery _____

Hysterectomy _____

Oophorectomy _____

Tubal Ligation _____

Cesarean Section _____

URINARY SURGERY DATE

Nephrectomy _____

Lithotripsy _____

Prostate Surgery _____

Continent Ureteral Diversion _____

GASTROINTESTINAL SURGERY DATE

Appendectomy _____

Gallbladder Surgery _____

Partial Colectomy _____

Colostomy _____

Ileostomy _____

Hemorrhoidectomy _____

Small Bowel Resection _____

Splenectomy _____

Pancreatectomy _____

Ulcer Care _____

Liver Transplant _____

HERNIA SURGERY DATE

Inguinal Hernia Repair Right Left _____

Umbilical Hernia Repair _____

Femoral Hernia Repair Right Left _____

Incisional Hernia Repair _____

Ventral Hernia Repair _____

Internal Hernia Repair _____

Hiatal Hernia/Nissan Fundiplication _____

MUSCULOSKELETAL SURGERY DATE

Back Surgery _____

Total Hip Replacement Right Left _____

Knee Replacement Right Left _____

Rotator Cuff Repair _____

Fracture: Location: _____

Provider Signature _____

Date _____

Name: _____

PATIENT MEDICAL HISTORY

Date: _____

Have you had any fall with injuries: _____ If yes, how long ago: _____

MEDICATIONS

Please list all medications you take, include any occasional or over the counter medications. Please put name, dosage/strength, and frequency of each medication. If you have a copy of your medication list on your computer, please print it and bring it with you.

ALLERGIES

Please list allergies to you have to any medications and non-medications, please include the reaction you had.

Provider Signature

Date



Patient Weight Loss & Medical History Questionnaire

NAME: _____ Sex: M F Age: _____

DOB: _____ Home Phone: _____ Work Phone: _____

Current Weight: _____ Current Height _____ BMI _____

INSURANCE INFORMATION

Insurance Name: _____

Does your Health Insurance cover weight loss surgery ? _____

If so what Pre-Approval Requirements do they have ?

Pre-Op Weight Loss ? _____ lbs

Medically Supervised Weight Loss Program Required _____, Length of time required _____

Duration of Obesity ? _____ Smoking cessation ? _____

Mental Health Clearance ? _____ Psychological or IQ testing ? _____

Other Requirements ? _____

PREVIOUS ATTEMPTS AT WEIGHT REDUCTION:

How many years have you been overweight? _____

Please estimate your weight at the following times:

Birth: _____

Marriage: _____

Lowest Weight in Past 5 Years: _____

Highest Weight in Past 5 Years: _____

1 st Pregnancy - year _____	start weight _____	weight at delivery _____
2 nd Pregnancy - year _____	start weight _____	weight at delivery _____
3 rd Pregnancy - year _____	start weight _____	weight at delivery _____
4 th Pregnancy - year _____	start weight _____	weight at delivery _____

FOOD PREFERENCES

Rate the following foods from 1 - 5. 1 for don't like very much and 5 for like very much (most likely to make you go off a diet)

- | | | |
|------------------------|--------------------|--------------------------|
| _____ soda/soft drinks | _____ French fries | _____ chips/salty snacks |
| _____ steaks/chops | _____ candy | _____ potatoes |
| _____ chocolate | _____ pasta | _____ cookies |
| _____ pizza | _____ cakes/pies | _____ salad dressings |
| _____ fried foods | _____ bread | |

Physician's signature _____

Date _____

NAME: _____

DIET PROGRAMS AND SUPPLEMENTS

Please indicate which of the following diets or plans you have tried:

PROGRAM	DATES	DURATION	MD SUPERVISED?	WEIGHT LOSS
_____ Weight Watchers	_____	_____	_____	_____
_____ Jenny Craig	_____	_____	_____	_____
_____ Metabolife	_____	_____	_____	_____
_____ Medifast	_____	_____	_____	_____
_____ Nutri/System	_____	_____	_____	_____
_____ Atkins Diet	_____	_____	_____	_____
_____ Herbalife	_____	_____	_____	_____
_____ SlimFast	_____	_____	_____	_____
_____ Grapefruit Diet	_____	_____	_____	_____
_____ Liquid Diet	_____	_____	_____	_____
_____ Pritikin Diet	_____	_____	_____	_____
_____ Optifast	_____	_____	_____	_____
_____ T.O.P.S	_____	_____	_____	_____

List any other physicians - supervised Weight loss attempts: _____

WEIGHT-LOSS MEDICATION HISOTRY

Please indicate if you have taken any of the following medications to lose weight

MEDICATION	DATES	DURATION	MD SUPERVISED?	WEIGHT. LOSS
_____ Amphetamines	_____	_____	_____	_____
_____ Phentermine (Adipex, Fastin, Pondimen)	_____	_____	_____	_____
_____ Phen-Fen	_____	_____	_____	_____
_____ Dexfenfluramine (Redux)	_____	_____	_____	_____
_____ Xenical (Orlistat)	_____	_____	_____	_____
_____ Meridia (Sibutramine)	_____	_____	_____	_____
Other Diet Medications:	_____	_____	_____	_____

Physician's signature

Date

NAME: _____

NON-DIETARY THERAPY: Please indicate if you have tried any of the following weight loss therapies.

THERAPY	DATES	DURATION	MD SUPERVISED?	WEIGHT. LOSS
_____ Exercise	_____	_____	_____	_____
_____ Hypnosis	_____	_____	_____	_____
_____ Behavior Modification	_____	_____	_____	_____
_____ Acupuncture	_____	_____	_____	_____

List any other weight loss methods you have tried: _____

PREVIOUS WEIGHT LOSS SURGERY: Yes No

Surgery	Type	Date	Surgeon	Wt. Loss
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Physician's signature

Date



K. Robert Williams, Jr., M.D. FACS, FASMBS

Contact Us
865-694-9676

Dear Physician,

Your patient is interested in weight loss surgery at the New Life Center for Bariatric Surgery. This patient may be required to complete a Medically Supervised Diet for a specified time by their insurance company. If you have been following the patient in the past for a medically supervised diet, we would appreciate it if you could provide documentation regarding diet and exercise efforts within the past year. Please fill out the attached form to correspond with each visit or send an office note from each office visit.

If the patient will be starting a medically supervised diet with your office, documentation from you must include:

- Monthly appointments with dates documented
- Monthly weights with dates documented
- Nutritional and Exercise counseling to aid weight loss
- Other recommendations made to aid weight loss

Please refer to the attached form for the proper documentation process required by insurance companies for all future appointments. **Please fax the documentation to (865) 588-3742 after each visit.**

Thank you for your time and attention to this matter and please contact us with any additional questions at (865) 694-9676.

Sincerely,

The Staff of New Life Center for Bariatric Surgery

9330 Park West Blvd, Suite 508,
Physicians Plaza
Knoxville, TN 37923
Fax 865-588-3742



Request for Documentation of Medically Supervised Diet & Exercise Visits (Please complete one for each visit And fax to 865-588-3742)

Physician conducting program: Physician Address:

Patient Name: Date of Visit: Chart #: Date of Birth: Initial Visit Date: Visit Number: Goal Weight:

- S: Patient is following a: 800 cal/day diet, 1200 cal/day diet, 1500 cal/day diet, Pre-op Diet, Other:

- Patient is participating in the following exercise regimen: Walking, Yoga/Pilates, Swimming, Aerobics, Curves, Gym/Club Membership, Water Aerobics, Physical Therapy, DVD/Video Tapes, Other: Pt Unable to Exercise due to: Dietician Consult: Scheduled, Completed, Date:

O: Height: Weight: BMI: HR: B/P:

- A: Morbid Obesity, Super Morbid Obesity, Change in Weight since last visit, Change in Body Mass since last visit, Patient verbalizes understanding of Carbohydrates, fats, and protein grams, Patient Keeps a Food Journal, Patient Keeps an Exercise Log and documents increase in physical activity, Patient has disability of Activities of daily living related to obesity, Patient is compliant with diet and exercise

- P: Continue on a: 800 cal/day diet, 1200 cal/day diet, 1500 cal/day diet, Pre-op Diet, Other: Continue Exercise, Return to Office in 1 month to evaluate Progress, Drug Therapy has been considered, Phentermine, Xenical, Declined, Other, Additional behavioral interventions, Other

Physician Signature



NAME : _____

What Do I Want to Know?

Our goal here at the New Life Center for Bariatric Surgery is to provide you with exceptional medical care and to be sure that all of your health concerns are addressed during your visit with our providers. We know that a great amount of information will be discussed at the time of your consultation and want to ensure that you have the opportunity to discuss any questions you have regarding all aspects of our program.

Please take a moment to write down in the space provided below any inquiries that you would like covered during your visit.

1. Q: _____

A: _____

2. Q: _____

A: _____

3. Q: _____

A: _____

4. Q: _____

A: _____

Thank you for giving us the opportunity to assist you in this journey toward your “New Life.”



Request for Medical Clearance from Primary Care Physician

Patient's Name: _____

Patient's Date of Birth: _____

Dear Physician,

We are currently evaluating your patient for bariatric surgery. To facilitate obtaining approval from the patient's insurance, we need the following:

1. A letter stating that your patient is "recommended and cleared" (this exact verbiage is required by some insurances) to undergo bariatric surgery. Please acknowledge previous weight loss attempts and comorbid conditions.
2. Documentation that the patient's Flu and Pneumonia vaccinations are UTD according to current recommendations
3. Previous weight history for Not needed 1 year 2 years 3 years 5 years
4. Medically supervised diet visits, must be monthly, consecutive without missing a month.
Total visits required: Not needed 4 months 6 months 7 months

Please fax this requested information to 865-588-3742

Thank you for your assistance and please feel free to contact me if you have any questions.

Sincerely,

PREPARING FOR YOUR CONSULTATION

Please make these preparations for your 1st appointment with your surgeon.

1. Call your insurance company and ask specifically “Do I have coverage for Weight Loss Surgery?” You may also need to say Bariatric Surgery.
2. Fill out your packet completely prior to coming in for your visit. If you are unable to do this prior to your visit or, you do not have your packet, please arrive 30 minutes prior to your scheduled appointment time to complete this paperwork.
3. Bring a complete list of your current medications, including any over the counter medications, as needed medications, or supplements that you may take.
4. Bring your photo ID and your Insurance card for this visit.

PART 2 (MUST BE COMPLETED BY ATTENDING PHYSICIAN, SOMEONE OTHER THAN BARIATRIC SURGEON OR HIS/HER ASSOCIATES):

Date: _____ Member Name: _____ Member BCBS/INS ID#: _____

Member Telephone: (home) _____ (work) _____ (cell) _____

Document adherence to a non-surgical weight loss program (e.g. dietary management, behavioral modification, and/or exercise) within two (2) years of request for surgery with participation for a minimum of 6 months:

List date and beginning weight: _____ Detail specifically what was being done for weight loss program:

Date and weight when non-surgical program ended : _____

Has this member been unable to achieve and / or maintain adequate weight loss (i.e. 10-percent of initial body weight) by conservative means? Circle response: YES NO

List Weights for the last five (5) years. At least one data set is required per year. (State of Tennessee members require the current weight and one year prior to document one full year.)

Current weight Date: _____ Height: _____ Weight: _____ BMI _____

Prior Year weight Date: _____ Height: _____ Weight: _____ BMI _____

Prior Year weight Date: _____ Height: _____ Weight: _____ BMI _____

Prior Year weight Date: _____ Height: _____ Weight: _____ BMI _____

Prior Year weight Date: _____ Height: _____ Weight: _____ BMI _____

List ALL of member's Past Medical history and current Diagnosis. _____

Please list current pertinent medications: _____

Please list pertinent labs, DME (C-Pap, etc) or testing as needed to support definition of Class 2 Obesity if needed:

Attending physician's name, address, telephone, and BCBS of TN provider number: _____

Attending physician's signature (Cannot be a Nurse Practitioner or Physician's Assistant)

_____ Date: _____

I have reviewed this patient's clinical information and recommend that they have the requested Bariatric surgery. By signing this documentation, I attest that the information contained above is correct, to the best of my knowledge, and that clinical record substantiating this documentation are available for review, if requested.

Financial Information for Bariatric Pre-Pay Patients

- **Packaged Price**

- Includes: Surgeon fees, Anesthesia fees, Hospital Stay for an uncomplicated case and BLIS Insurance (which protects you from specified complications during specified times).
- Does **not** include items such as outpatient labs, radiology interpretations, fees for physicians outside our practice, or other services that are unique to one patient.
- Varies by type of surgery (see below).

Adjustable Gastric Banding	\$17, 750
Gastric Sleeve	\$16, 750
Gastric Bypass – RNY	\$22, 100
Biliary Pancreatic Diversion	\$25, 750
Revisional Surgery	Varies by type

You will also be responsible for fees for labs and other testing as you go through the process of getting ready for surgery. We will try to keep you informed of what these fees are but please feel free to ask at any time.



Financial Information for Patients with Insurance Coverage

Thank you for expressing an interest in the New Life Center for Bariatric Surgery Program. We understand that one of your biggest concerns may be the cost of Bariatric Surgery. This page is intended to introduce you to the process of determining your financial ability to obtain Bariatric Surgery in our program.

- If treatment / surgery for obesity is a **PLAN EXCLUSION** on your policy, your insurance company WILL NOT PAY for Bariatric Surgery regardless of the need. Please contact your insurance plan and ask if there is a plan exclusion before going any further.
- If treatment / surgery for obesity is covered on a Medically-Necessary basis, this means that they will pay toward your surgery expenses if you meet their criteria. It is best to wait until we have gathered all the information about your history and current condition before attempting to prove medical necessity. Our office will assist you with this process.
- You can apply for financing with the following entity.
 1. Prosper Healthcare Financing
<http://www.newlifebariatricsurgery.com/how-do-i-become-a-patient/bariatric-financing-insurance-knoxville-tn/>
- The total cost of surgery services varies according to type of surgery, any medical clearances needed, insurance coverage and services that you require.
- Payment Schedule

Consultation Day

-Surgeon's bill and co-pay, file to insurance

Pre-Admission Testing Day

-Hospital Deposit \$500 or less, depends on insurance

-After surgery balances left by insurance.



Partnering with



IMPROVING ACCESS TO WEIGHT LOSS SURGERY

Peace of Mind for the Bariatric Pre-Pay Patient

The New Life Center for Bariatric Surgery is proud to announce their affiliation with BLIS (www.bliscompany.com). Becoming a BLIS surgeon is a very selective process as determined exclusively by BLIS. This means that Dr. K. Robert Williams, Jr., M.D. meets very high standards of short term outcomes and long term patient success.

As a result of our approval by BLIS we are able to participate in an innovative new insurance coverage which allows us to make a commitment to our bariatric pre-pay patients that in the event a covered complication occurs within certain time frames following surgery, our patients are not responsible for the costs associated with the care of that complication.

**The complication protection is exclusively part of the package price you will pay for your weight loss surgery. We are happy to provide this benefit to our patients and ease your mind and your wallet in this important decision to have life-saving surgery.

**Other term and conditions apply; please contact our office and see the bariatric pre-pay contract for further details about this program.



NAME : _____

My Activity

Help us to understand your present day activity status. Please check below the statements that best describe your abilities at your current weight.

- Self reliant in usual daily activities.
- Difficulty getting out of bed on one's own.
- Difficulty getting on the toilet
- Difficulty going to the bathroom using hand bar.
- Difficulty going to the bathroom using elevated seat.
- Difficulty washing oneself.
- Difficulty dressing oneself.
- Difficulty putting on upper garments.
- Difficulty grooming
- Difficulty tying shoes.
- Unable to tie shoe laces.
- Unable to sit in a desk chair.
- Use of cane for walking.
- Limited ambulation with walker,
- Wheel Chair Dependent.
- Difficulty breathing during exertion.
- Unable to walk for more than _____ feet.
- Unable to walk for more than ___ min.
- Difficulty breathing after walking up _____ flights of stairs.
- Difficulty with activities of daily living.
- Unable to do ones own housecleaning.
- Unable to manage one's own money.

Physician's signature

Date

Patient's Name _____ Date of Birth _____

Missed Appointment Fees – In order to provide the best care and service to our patients, we ask that you notify us 24 hours in advance to cancel and/or reschedule your office visit, ultrasound or other diagnostic test appointment. A minimum of 30 and up to 90 minutes is set aside for each appointment and your communication and compliance is much appreciated by your physician and supporting staff.

Please be aware that if 24 hour notice is not received a fee of \$25 may be charged to your account which must be settled before another appointment is scheduled.

Please call us if you are unable to keep your scheduled appointment. This will provide us an opportunity to reschedule your appointment to a more convenient time and avoid any additional charges on your account.

Self-Pay Accounts – For patients who have no insurance plan, payment is expected at the time of service for all services including surgeries. If a procedure or surgery is scheduled, a deposit of at least \$150 will be required at the time of scheduling. If you need to make payment arrangements please contact us at 865-306-5700.

Collection Accounts - A collection fee of 30% will be added to all accounts that are turned over to collection agencies.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGED

I have been given an opportunity to review, ask questions about and understand Premier Surgical Associates' Notice of Privacy Practices for Protected Health Information (Notice).

FINANCIAL RESPONSIBILITY

I understand and commit to the following:

1. I have received a copy of Premier's financial policies and have read and understand these policies.
2. I will pay my co-pay, deductible and co-insurance at the time of service.
3. I will provide the most current insurance information and immediately notify Premier of changes.
4. If surgery is required, all or a portion of my financial responsibility must be paid prior to surgery.
5. I will follow my insurance company's requirements for referrals and pre-authorizations and I understand that if I fail to do so, my insurance benefits will be reduced and I will be responsible for all denied balances.
6. I understand that I am responsible for all balances.
7. If I have no insurance, I have informed Premier and I am responsible for 100% of all balances.
8. A collection fee of 30% will be added to all my accounts that are turned over to collection agencies.

INSURANCE AUTHORIZATION AND RELEASE

I request that payment of authorized benefits – including Medicare, and any other government sponsored program, private insurance, and any other health plans – be made to **Premier Surgical Associates, PLLC** for any services furnished by that provider. I authorize any holder of medical information about me to release to those persons or companies presenting a legitimate request for such information needed to determine these benefits or the benefits payable for related services. I authorize **Premier Surgical Associates, PLLC** to act as my agent to help me obtain any required pre-certification as well as acting as my agent to help me obtain payment from my insurance companies. I authorize my insurance companies to give **Premier Surgical Associates, PLLC** any information they require to fulfill this function. This will remain in effect until revoked in writing. A photocopy of this assignment and release is to be considered as valid as the original.

Patient's Signature _____ Date _____

PATIENT INFORMATION FORM (PLEASE PRINT)

Patient Name (First, Middle, Last) _____

Preferred Name (What you go by) _____

Social Security Number _____ Date of Birth _____

Sex (circle one): Male Female Martial Status (circle one): Single, Married, Divorced, Widowed, Legally Separated

Race (circle one): Caucasian/White, Latino/Hispanic, Black or African American, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, Other, Not Reported/Refused

Ethnicity (circle one): Caucasian/White, Latino/Hispanic, Black or African American, Other, Not Reported/Refused

Language (circle one): English, French, Spanish, Chinese, Japanese, Korean, Sign Language, Vietnamese

Employment Status (circle one): Employed, Unemployed, Self Employed, Disabled, Retired, Full-Time Student, Part-Time Student

Patient Mailing Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

(By including your cell phone number, you have given Premier consent to call your cell phone for appointment reminders using our automated system)

E-Mail _____

Employer _____ Occupation _____

Referring Physician (please include phone number) _____

Other *Current* Healthcare Providers (please provide first and last name and phone number):

Primary Care _____ Cardiology _____

Pulmonary _____ Endocrinology _____

Nephrology _____ Dialysis Center _____

Other: _____

MEDICAL RECORDS RELEASE

I hereby authorize Premier Surgical Associate, PLLC to release any information in my chart to any medical practitioner, doctor, hospital, medical institution to who I may be referred to assist with my care. Additionally, I authorize any request for medical information from any medical practitioner, doctor, hospital, medical institution assist in my care.

Patient's Signature _____ Date _____

Patient's Name _____ Date of Birth _____

EMERGENCY CONTACT INFORMATION

Contact Name (First, Middle, Last) _____

Sex (circle one): M F Patient Relationship to Contact (circle one): Child, Wife, Husband, Parent, Grandparent, Other

Language (circle one): English, French, Spanish, Chinese, Japanese, Korean, Sign Language, Vietnamese, Other

Home Phone _____ Work Phone _____ Cell Phone _____

Contact is a Parent/Guardian (circle one): Yes No

If patient is under the age of 18, Emergency Contact should be a Parent or Guardian unless patient is an Emancipated Minor

PHARMACY

Preferred Pharmacy _____ Phone No. _____

Pharmacy Address _____

City, State, Zip _____

CONSENTS

Do you have any of the following (please circle all that apply):

Living Will, Do Not Resuscitate (DNR), Power of Attorney, End of Life Decision, No Cardio-Pulmonary Resuscitation (CPR)

PHONE MESSAGES

Please check yes or no:

Yes No Premier may leave messages on my answering machine at HOME.

Yes No Premier may leave messages on my CELL PHONE VOICEMAIL.

Yes No Premier may leave messages with my EMPLOYER/WORK.

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my healthcare provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function. I also authorize my healthcare provider to disclose to third parties limited protected health information (PHI) regarding my healthcare events. I consent to the receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages being left on my voice mail, answering system, or with an individual, if I am unavailable at the number provided by me.

Patient's Signature _____ Date _____



Patient's Name _____ Date of Birth _____

INSURANCE INFORMATION

PRIMARY Insurance Company _____

Group No. _____ Member ID _____

Primary Insurance Subscriber (circle one): Patient Other Sex (circle one): Male Female

Subscribers Name (First, Middle, Last) _____

Subscriber's Social Security Number _____ Date of Birth _____

Marital Status (circle one): Single, Married, Divorced, Widowed, Legally Separated

Employment Status (circle one): Employed, Unemployed, Self Employed, Disabled, Retired, Full-time Student, Part-time Student

Subscribers Employer _____

Subscribers address (if different from patient) _____

City, State, Zip _____

Subscribers Home Phone _____ Work Phone _____ Cell Phone _____

Patient Relationship to Subscriber (circle one): Self, Child, Wife, Husband, Parent, Other

SECONDARY Insurance Company _____

Group No. _____ Member ID _____

Primary Insurance Subscriber (circle one): Patient Other Sex (circle one): Male Female

Subscribers Name (First, Middle, Last) _____

Subscriber's Social Security Number _____ Date of Birth _____

Marital Status (circle one): Single, Married, Divorced, Widowed, Legally Separated

Employment Status (circle one): Employed, Unemployed, Self Employed, Disabled, Retired, Full-time Student, Part-time Student

Subscribers Employer _____

Subscribers address (if different from patient) _____

City, State, Zip _____

Subscribers Home Phone _____ Work Phone _____ Cell Phone _____

Patient Relationship to Subscriber (circle one): Self, Child, Wife, Husband, Parent, Other



Patient's Name _____ Date of Birth _____

WORKERS COMPENSATION or AUTO INSURANCE INFORMATION

Your Supervisor _____ Supervisor's Phone No. _____

Workers Compensation or Auto Insurance Phone No. _____

Claims Address _____

City, State, Zip _____

Adjusters Name _____ Adjusters Phone No. _____

Claim No. _____ Approval No. _____

Date of Injury _____ Did injury occur at work (circle one): Yes No Auto Accident (circle one); Yes No

Briefly describe injury or accident: _____

FOR MEDICARE SUPPLEMENT POLICIES ONLY
ONE-TIME MEDIGAP ASSIGNMENT AND RELEASE

Name _____ Medicare Number _____

Medigap Policy Name _____ Medigap Policy Number _____

I request that payment of the authorized Medigap benefits be made on my behalf to Premier Surgical Associates, PLLC for services furnished to me by them. I authorize any holder of medical information about me to release it to:

Name of Policy _____

any information needed to determine these benefits or the benefits payable for related services. This will remain in effect until revoked in writing. A photocopy of this assignment and release is to be considered as valid as the original.

Patient's Signature _____ Date _____



PATIENT MEDICAL RECORD RELEASE AUTHORIZATION

Date: _____ Patient Date of Birth: _____

Patient Name: _____

I hereby authorize the release of my personal health information to the following relatives or individuals:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

For the purpose of you treatment and our payment and operations we will disclose your protected health information to physicians, other medical professionals, hospitals and insurance companies, Otherwise it is our policy to release such information only to the patient unless otherwise specified to do so by you in writing. **This authorization will not expire unless revoked by you by giving us written notice of such revocation.** Information disclosed under this authorization may be disclosed again by the person or organization to which it is given and is no longer protected by federal privacy regulations.

I hereby authorized New Life Bariatric/Premier Surgical to release my protected health information to the individuals listed above.

Patient's Signature _____ Date _____