

**Thank you for downloading our packet of new patient instructions and forms. Please review all of the information, including the Notice of Privacy Practices (HIPAA)**

**Please complete pages 6 through 13 and bring with you to your visit.**



# Welcome to Tyler Bariatrics!

Our goal is to help individuals achieve better health through surgical and non-surgical management of obesity.

## Who We Are

**Hugh P. Babineau, MD, FACS**

Bariatric Surgeon. Ten years experience and over 3000 bariatric (weight loss) operations performed. Certified as a Surgeon of Excellence by the American Society for Metabolic and Bariatric Surgery ([www.asmb.org](http://www.asmb.org)).

**Freda Fleet, LVN**

Bariatric Program Coordinator. Bariatric Nutritionist

**Lindsay Carter, LVN**

Bariatric Nurse

**Lynda Schmidt, ACNP**

Certified Acute Care Nurse Practitioner. Surgical First Assistant (RNFA)

**April Mahfood, RD**

Registered Dietician

**Suzanne Strickland**

Medical records

**Robin Wilkins**

Business office

## For More Information

**Office: 903-593-0230**

Fax: 903-597-3015

1100 E. Lake, suite 150

Tyler, TX 75701

[www.tylerbariatrics.com](http://www.tylerbariatrics.com)

American Society for Metabolic and Bariatric Surgery

[www.asmb.org](http://www.asmb.org)

Centers of Excellence

[www.surgicalreview.org](http://www.surgicalreview.org)

Support Groups

Call the office for times and locations.

Nutrition Refresher Classes (postop)

Mondays - call the office for times

## What We Offer

**Surgeries:** Laparoscopic Gastric Bypass Laparoscopic Sleeve Gastrectomy, Revisions, Lap-Band®.

**Experience and Specialization:** Ten years and over 3000 patients. Bariatric surgery *is what we do*.

**Pre-operative Weight Management Program.**

**Support groups and post-operative nutrition classes.**

**Sophisticated facilities:** Tyler is the tertiary referral center for East Texas, with the full range of specialists, advanced facilities and technology. Surgeries are performed at East Texas Medical Center and Trinity Mother Frances Hospital.

## Instructions For Your First Visit

Scheduled for: \_\_\_\_\_

1. Please prepare to spend 3 to 4 hours with us. The visit will include an orientation, a small group seminar with Dr. Babineau, and an individual one-on-one consultation with Dr. Babineau. We encourage you to bring your spouse or other support person with you. Please do not bring babies or young children.
2. **Please complete and sign the enclosed forms to the best of your ability.**
3. Contact your insurance company to see if they have benefits for "Laparoscopic Sleeve Gastrectomy," CPT 43775, "Laparoscopic Gastric Bypass," CPT code 43644, or "Laparoscopic Adjustable Gastric Band (Lap-Band)" CPT code 43770. Call the customer service number on your ID card, and be persistent! Find out what they require to approve surgery, and start gathering any supporting documents and records.
4. Bring your insurance ID card, completed forms, and records to the appointment. **We look forward to meeting you!**

## NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully**

The Health Insurance Portability & Accountability Act of 1996 (“HIPAA”) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used.

“HIPAA” provides penalties for covered entities that misuse personal health information.

As required by “HIPAA”, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your medical records only for each of the following purposes: **treatment, payment, and health care operations**.

**Treatment** means providing, coordination, or managing health care and related services by one or more health care providers. An example of this would include an office examination.

**Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

**Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example would be an internal quality assessment review.

We may also create and distribute unidentified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the attention of the Privacy Officer:

- 1) The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do not agree to the restriction, we must abide by it unless you agree in writing to remove it.
- 2) The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- 3) The right to inspect and copy your protected health information.
- 4) The right to amend your protected health information.
- 5) The right to receive an accounting of disclosures of protected health information.
- 6) The right to obtain a paper copy of the Notices of Privacy Practices form upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003, and we are required to abide by the terms of the Notices of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or the Department of Health & Human Services, Office of Civil Rights about violations of the provisions of this notice or the policies and procedures of our office.

We will not retaliate against you for filing a complaint.

### Please contact us for more information:

Hugh P. Babineau, MD, FACS  
1100 East Lake St., Ste. 150  
Tyler, Texas 75701  
(903) 593-0230

U.S. Department of Health & Human Svcs.  
Office of Civil Rights  
1301 Young Street, Ste. 1169  
Dallas, Texas 75202  
(214) 767-4056  
(877) 696-6775 - Toll Free

## DEFINITIONS

### **HIPAA: Health Insurance Portability and Accountability Act of 1996**

A federal law that requires the use of national identification systems for healthcare patients, providers, payers (or insurance plans), and employers or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable healthcare information.

### **PHI: Protected Healthcare Information**

Individually identifiable health information (IIHI) held or disclosed by a physician's office regardless of how it is communicated (e.g., electronically, verbally or written).

### **IIHI: Individually Identifiable Health Information**

Any health information (including demographics/addresses, etc) that is collected from the patient or created or received by a healthcare provider or other covered entity or employer that relates to the past, present or future physical or mental health or condition of an individual OR the provision of healthcare or the past, present or future payment for the provision of healthcare at your physician's office AND that could potentially identify an individual. (e.g. Name/address/birth date/phone number, etc.)

### **Healthcare**

Healthcare includes, but is not limited to preventive, diagnostic, therapeutic, rehabilitative maintenance, or palliative care, and counseling service, assessment, or procedure with respect to the physical or mental condition, or functional status of an individual or that affects the structure or function of the body; and sale or dispensing of a drug, device, equipment or other item in accordance with a prescription.

### **Healthcare Operations**

Activities related to business, clinical management and administrative duties. Some examples of these activities are the use of **PHI** (Personal Health Information) to obtain a referral, quality assurance, quality improvement, case management, training programs, licensing, credentialing, certification, accreditation, compliance programs, business management and general administrative duties of the physician's office.

### **TPO: Treatment, Payment, Healthcare Operations**

We as the physician's office can disclose protected healthcare information needed to conduct daily business.

**HIPAA: Patient Consent For Use and Disclosure of Protected Health Information**

With my consent, Hugh P. Babineau, MD, PA (doing business as “Tyler Bariatrics”) May use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to the Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Tyler Bariatrics reserves the right its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices May be obtained by forwarding a written request to Tyler Bariatrics, at 1100 East Lake St, Suite 150, Tyler Texas 75701.

With my consent, the providers at Tyler Bariatrics or staff may *make calls* to my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With my consent, the providers at Tyler Bariatrics or staff may *send mail* to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and insurance statements as long as they are marked Personal and Confidential.

With my consent, the providers at Tyler Bariatrics or staff may *e-mail* to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders and insurance statements.

I have the right to request that Tyler Bariatrics restrict how it uses or discloses my PHI to carry out TPO, However, the practice is not required to agree to my requested restrictions, but if it does, is bound by the agreement.

By signing this form, I am consenting to Tyler Bariatrics use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Dr. Babineau and/or the other providers at Tyler Bariatrics may decline to provide treatment to me.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient’s Name (printed)

\_\_\_\_\_  
Legal Guardian’s Name

## Statement of Financial Responsibility

Hugh P. Babineau, MD, Lynda Schmidt, ACNP and the other providers at Tyler Bariatrics are in private practice and bill independently from the hospital for all services, such as office visits and surgery. (Routine postop visits are included in the surgery fee, up to 90 days from the surgery). If you have health insurance, our office will file claims in accordance with usual practices. We cannot, however, verify insurance benefits for all patients in advance of their office visit.

**Co-pays and deductibles:** All or part of provider services are sometimes denied payment by insurance companies. Examples of reasons include: the provider is out of network, certain services are not eligible, you have been dropped by the plan, the plan has been cancelled by the employer, your plan does not cover certain diagnoses such as obesity or morbid obesity. Even if your surgery and office visits are approved by insurance, most insurance plans have a co-pay or deductible that the patient is required to pay to the physician, hospital or other provider of care. Any amount of our fees that the insurance does not pay, (up to the amount allowed by the insurance contract if one of our providers is a participating provider) is the patient's responsibility.

**Participation in insurance plans or networks:** Our providers participate in numerous insurance plans. This means that we are "in-network provider" for many plans, such as BlueCross BlueShield and United Healthcare, but may be "out-of-network" for others. If we are "out-of-network," most plans will allow you to use us for your surgery and other care, but we are not obligated to accept as full payment what the plan pays. In other words, you will probably have a larger out-of-pocket payment if Dr. Babineau does your surgery and is out-of-network.

**Other providers to whom you will be financially responsible include:** assistant surgeon, hospital, and anesthesiologist. In addition, you may be billed by other providers such as a radiologist, pathologist or other physicians asked to take part in your care.

Although we will file claims with your insurance, you are ultimately responsible for all fees for services rendered by Dr. Babineau *and all of the other providers involved in your care.*

By signing below, you are indicating that you have read and understood all of the above information. You are also agreeing to pay for any and all services rendered by Dr. Hugh P. Babineau, MD and other providers involved in your care.

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Signature of Patient or Legal Guardian

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Date

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Patient's Name (printed)

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Legal Guardian's Name

### Patient Information Sheet

Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_ Sex \_\_\_\_\_

Race \_\_\_\_\_ Gender \_\_\_\_\_ Marital Status \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Mobile \_\_\_\_\_

Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_

**Primary Insurance Holder Information**       Same as above

Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_ Sex \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Mobile \_\_\_\_\_

Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_

Emergency contact and phone# \_\_\_\_\_

Primary Physician and phone# \_\_\_\_\_

Pharmacy and phone# \_\_\_\_\_

Primary Insurance \_\_\_\_\_

Secondary Insurance \_\_\_\_\_

**ASSIGNMENT OF INSURANCE BENEFITS**

Patient's Name \_\_\_\_\_

I authorize **Hugh P. Babineau, MD, PA** to submit claims to my insurance carrier for benefits for myself, my spouse, or dependent and receive payment for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted. I agreed that I will be bound by this signature as though I had personally signed the claim form. I hereby assign directly to **Hugh P. Babineau, MD, PA** all insurance benefits otherwise payable to me for his services. I authorize any insurance company of mine to pay **Hugh P. Babineau, MD, PA** directly for any bill incurred by me, my spouse, or dependent.

\_\_\_\_\_  
Signature of Insured\_\_\_\_\_  
Date**MEDICARE AUTHORIZATION**

Patient's Medicare Number \_\_\_\_\_

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Hugh P. Babineau, MD, PA** for any services provided to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claims. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing information to the insurer or agency shown. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

\_\_\_\_\_  
Beneficiary Signature\_\_\_\_\_  
Date**RELEASE OF INFORMATION**

I hereby authorize **Hugh P. Babineau, MD, PA** to send a copy of my medical records to my referring physicians and my insurance companies. I hereby authorize the release of any information relating to all insurance claims for benefits submitted on my behalf.

**I understand that this authorization in no way releases me from primary responsibility for the payment of my bill and I understand that I am financially responsible for all charges incurred whether or not paid by my insurance.**

\_\_\_\_\_  
Signature of Patient (or Parent if minor)\_\_\_\_\_  
Date

Who is your primary physician? \_\_\_\_\_

How were you referred to Dr. Babineau? \_\_\_\_\_

### Obesity History

How long have you been overweight? \_\_\_\_\_

What is the most you have ever weighed, and when? \_\_\_\_\_

Please list any diets, medications or other weights loss attempts. Give dates, if you can:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Medical and Surgical History

Do you have **hypertension** (high blood pressure)? .....Yes No

If "yes", how many medications do you take for hypertension? .....

Do you have **congestive heart failure** (CHF)?.....Yes No

Do you have **coronary artery disease** or any other heart problems?.....Yes No

If "yes" to heart disease, describe \_\_\_\_\_

Do you have **angina** or chest pains?.....Yes No

Do you have any **vascular disease** (blockages in arteries other than heart)? .....Yes No

If "yes" to vascular disease, describe \_\_\_\_\_

Do you have **fluid retention** (edema) in your feet, ankles or legs? .....Yes No

Have you had a **Deep Venous Thrombosis** (DVT) or Pulmonary Embolus(PE)? .....Yes No

If "yes" to DVT or PE, describe \_\_\_\_\_

Do you have **Diabetes**?.....Yes No

If "yes" to diabetes, when was it diagnosed?\_\_\_\_\_

If "yes" to diabetes, do you take insulin, oral meds or no meds? \_\_\_\_\_

Do you have **high cholesterol** or high lipids?.....Yes No

Do you take medications for **high cholesterol or high lipids**?.....Yes No

Have you had any problems with **gout**?.....Yes No

Do you have **Sleep Apnea**? (Stop breathing at night)?..... Don't know Yes No

If "yes" to Sleep Apnea, has it been diagnosed by a physician or sleep test?.....Yes No

Do you use a breathing machine at night (CPAP or BiPAP) for sleep apnea?.....Yes No

Do you have **asthma** or any other breathing problems?.....Yes No

If "yes," describe \_\_\_\_\_

Do you have **GERD** (acid reflux)?.....Yes No

How often do you have GERD symptoms? .....

List any medications you take for GERD .....

Have you had gallstones or **gallbladder problems**?..... Don't know Yes No

If "yes", give details:.....

Have you had any **liver disease** or problems?.....Yes No

If "yes", give details:.....

Do you have **back pain**?.....Yes No

If "yes," give details:.....

Do you have **fibromyalgia**?.....Yes No

Have you been diagnosed with **arthritis** in any joints?.....Yes No

Have you had any joints replaced?.....Yes No

Do you have joint pains that have no been diagnosed as arthritis?.....Yes No

Please give details on joint pains and arthritis (which joints, etc.) .....

Do you have **Polycystic Ovarian Syndrome** (PCOS)?..... Don't know Yes No

Do you have any other menstrual (female) problems such as heavy bleeding? .....Yes No

If yes, describe .....

Do you have **Depression**? .....Yes No

If yes, how is it treated? .....

Have you ever been hospitalized for Depression? .....Yes No

Have you been diagnosed with **any other mental health conditions** , such as Bipolar Disorder, Panic Disorder, Generalized Anxiety, Psychosis, or Personality Disorder? .....Yes No

If "yes," please describe.....

Do you smoke or use smokeless tobacco? .....Yes No

If "yes" to tobacco, describe (packs per day, etc) .....

Do you drink any alcohol?.....Yes No

If "yes" to alcohol, how much, how often? .....

Do you use any "recreational" or illegal drugs? .....Yes No

Do you have any **urinary incontinence** (leakage of urine)? .....Yes No

If "yes", how often? .....

Do you have **Pseudotumor Cerebri**? ..... Don't know Yes No

Do you have a **hiatal hernia**? ..... Don't know Yes No

Do you have an abdominal **hernia** or problems with your abdominal skin?.....Yes No

If yes, describe .....

Check any others that apply and include date of onset and any other comments:

Infertility \_\_\_\_\_

Kidney Problem \_\_\_\_\_

Stroke \_\_\_\_\_

Cancer \_\_\_\_\_

Epilepsy / Seizures \_\_\_\_\_

**List all surgeries:**

<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

**Please list any other hospitalizations, diseases, conditions:**

<hr/>
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**List all medications, including over-the-counter (or attach list):**

<hr/>	<hr/>
<hr/>	<hr/>
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**List all vitamins and supplements:**

<hr/>	<hr/>
<hr/>	<hr/>

**List any allergies, including what the reaction was (rash, itching, etc.)**

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# Last Page - almost finished! 😊

Are you under the care of a psychiatrist or other mental health provider? .....Yes No

Name of mental health provider.....

Have you had any problems with anesthesia? .....Yes No

If "yes", describe .....

Do you have a history of excessive bleeding?.....Yes No

If "yes" to bleeding, give details: .....

What is your occupation? \_\_\_\_\_

If employed, part-time or full? \_\_\_\_\_

What is your marital status? \_\_\_\_\_

## Review of Systems

Please check if you have the following:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Fevers or chills       | <input type="checkbox"/> Bleeding tendency    | <input type="checkbox"/> Leakage of urine |
| <input type="checkbox"/> Chest pain             | <input type="checkbox"/> Frequent headaches   | <input type="checkbox"/> Depression       |
| <input type="checkbox"/> Bloody bowel movements | <input type="checkbox"/> Excessive fatigue    | <input type="checkbox"/> Skin problems    |
| <input type="checkbox"/> Constipation           | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Vision problems  |
| <input type="checkbox"/> Painful urination      | <input type="checkbox"/> Diarrhea             | <input type="checkbox"/> Anxiety          |
| <input type="checkbox"/> Bone pain              | <input type="checkbox"/> Acid reflux          |   |

## Which Surgery are you seeking at this time?

Laparoscopic Gastric Bypass No Preference

Laparoscopic Sleeve Gastrectomy Not Sure

Laparoscopic Adjustable Gastric Band (Lap-Band)

## ✓ Verification - Please sign and date

The information I have provided above on all pages is accurate and complete to the best of my knowledge.

Signed \_\_\_\_\_ Date \_\_\_\_\_