Michael A. Todd, MD, FACS
Deborah A. Warner, MD
Alaska Bariatric Center
PO Box 143595
Anchorage, AK 99514
Phone (907)929-4263 Fax
(907)929-4267
mailcentral@alaskabariatric.com
www.alaskabariatriccenter.com

WELCOME to Alaska Bariatric Center. Thank you for choosing us for your weight loss journey.

Location: 4100 Lake Otis Parkway, Ste #302; Anchorage, AK 99508

Office Hours: 8:00am-4:00pm Monday through Friday.

Closed on: New Year's Day, President's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Holiday, and Christmas Holiday.

Dr. Michael Todd and his professional staff will do their best to provide you with exceptional healthcare, quality administrative and billing support as well as provide answers to any questions or concerns you may have. As we begin our medical and business relationship, we would like to inform you of some important details about our office.

Please check out our website at www.alaskabariatriccenter.com along with our Facebook page at www.facebook.com/alaskabariatriccenter. We also have an affiliated website of www.obesityhelp.com, and the ASMBS website at www.asbs.org for additional information on Bariatric surgery

Before starting our journey together, we need some more information from you and some signed documents. This is our Intake packet, and consists of the following 12 pages. Please include a copy of the following when submitting this packet:

☐ Driver's license or other state issued photo identification.
☐ All insurance cards, including Medicare and/or Medicaid card.
☐ A complete list of your medications.

Once we have received your Intake Packet (either by fax – 907-929-4267; or email – mailcentral@alaskabariatric.com) we will contact you to schedule an Orientation and Intake appointments. Typically, an Orientation is a group telemedicine meeting where Dr. Todd presents basic information about the process leading up to potential surgery. Immediately after the Orientation (same day), you will have a one-on-one telemedicine appointment with Dr. Todd to discuss your specific needs, goals, and requirements

As a general surgeon, and a specialist in bariatric surgery, Dr. Todd may be called out of the office at any given time. Orientation and Initial appointments are subject to change. We request that you please be patient and courteous to our staff should your appointments be delayed, or rescheduled. Please keep in mind that you shall receive the same priority services should you ever require emergency medical attention while under Dr. Todd's care. We appreciate your patience, diligence and again, thank you for choosing Alaska Bariatric Center. We look forward to serving you and being a part of your healthcare journey.

Sincerely,
Dr. Todd and the Alaska Bariatric Center Team

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# 2021

# PATIENT INFORMATION FORM

## PATIENT INFORMATION

NAME – LAST: ______________________________ FIRST: _____________________________________ M.I.: ____

DATE OF BIRTH: _________________ GENDER: M / F NICKNAME: ___________________________________

HEIGHT: ______________ WEIGHT: __________ MARITAL STATUS:______________________________

MAILING ADDRESS: ____________________________________ CITY: ___________________ STATE: _____ ZIP: ______

PHYSICAL ADDRESS: ___________________________________ CITY: ___________________ STATE: _____ ZIP: ______

HOME PHONE: ________________________ CELL: __________________________ WORK: _________________________

EMAIL: _____________________________________

## PARENT/GUARDIAN/SPOUSE

RELATIONSHIP TO PATIENT____________________________

NAME – LAST: ____________________________________ FIRST: _____________________________________ M.I.: ____

DATE OF BIRTH: _________________ GENDER: M / F

ADDRESS: ____________________________________________ CITY: ___________________ STATE: _____ ZIP: ______

HOME PHONE: _________________________ CELL: __________________________ WORK: _________________________

EMAIL: _____________________________________

## PRIMARY MEDICAL INSURANCE

Date of Accident/Injury:________________ CARDS SCANNED_________

___________________________________________________________________________________________________

(Primary Insurance Company Name) (ID#) (Group#)

___________________________________________________________________________________________________

(Policy Holder Name) (INSURED Date of Birth)

## SECONDARY MEDICAL INSURANCE

CARDS SCANNED_________

___________________________________________________________________________________________________

(Secondary Insurance Company Name) (ID#) (Group#)

___________________________________________________________________________________________________

(Policy Holder Name) (INSURED Date of Birth)

## EMERGENCY CONTACT INFORMATION

___________________________________________________________________________________________________

(Name) (Phone)

___________________________________________________________________________________________________

(Relationship)

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## AGREEMENT FORMS (please initial or sign as indicated)

- May we leave you a detailed message: At home? YES NO Cell? YES NO
- May we use your pictures and generic patient information for the following reasons; medical conventions *and/or* conferences, and/or discussions regarding issues at Bariatric Support Group meetings. YES NO
- May we post your picture on the website (alaskabariatriccenter.com)? YES NO
- May we show your picture *and/or* video's including pre and post-surgical weight at the Alaska Bariatric Center's Annual Gala? YES NO
- May Dr. Todd and other staff members include your patient information in text messages regarding your care, understanding that typical text messages are not HIPAA secure, To You YES NO
  With our office staff YES NO or other providers? YES NO
- May Dr. Todd and other staff members include your patient information in email messages regarding your care, understanding that typical email communications are not HIPAA secure, To You YES NO
- May we send a detailed appointment reminder information to your, Cell (voice message) YES NO
  Cell (Text Message) YES NO Email YES NO

Date Signed: ___________Patient Printed Name: ______________________Signature of Patient: ________________________

## NOTICE OF SOCIAL MEDIA POLICY

I, the undersigned am aware that any contact with Alaska Bariatric Center and its staff may be documented and included in my medical records. This includes but is not limited to; emails, text messages, and all other forms of social media.

Signature of Responsible Party: ________________________________________________________Date:____________________

## AGREEMENT TO PAY FOR TREATMENT

I, the responsible party, herby agree to pay all charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization with which this office has a contractual agreement, I agree to pay all applicable co-payments, co-insurance and deductibles, which arise during the course of treatment for the patient. The responsible part also agrees to pay for treatment rendered to the patient, which is not considered to be a covered service by my insurer and/or a third party insurer or other payer.

Signature of Responsible Party: ________________________________________________________Date:____________________

## RELEASE AND STATEMENT TO PERMIT PAYMENT OF PRIVATE INSURANCE BENEFITS TO THE PROVIDER

I, the undersigned responsible party hereby authorize this office/its employees to release and disclose all or any part of the patient's medical records to any entity which is, or may be liable, for all or part of the provider charges.

I, authorize the release and disclosure of any and all of my or my child's medical records to any other entity, including, but not limited to specialty physicians, hospitals, or other health care providers which may be of assistance in the opinion of this office, in providing treatment of the patient.

I, authorize the release of records necessary to assist in the reimbursement of benefits to which I may be entitled.

I, authorize this office, and/or its employees to release, via fax machine, medical records which are needed in order to provide the patient with the most appropriate medical care.

I, authorize and request that payment of any third party or insurance company benefits be made directly to this office for any services furnished to the patient. The signature furnished below shall suffice for all insurance forms on a continuing basis.

Signature of Responsible Party: ________________________________________________________Date:____________________

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## AKNOWLEDGEMENT OF EMERGENT CARE PRIORITY POLICY (DR. TODD PATIENTS)

As a general surgeon, and a specialist in bariatric surgery, Dr. Todd may be called out of the office at any given time. We request that you please be patient and courteous to our staff should your appointment be delayed, or rescheduled. Please bear in mind that you shall receive the same priority in service should you ever require emergent medical attention while under Dr. Todd's care.

Signature of Responsible Party: ______________________________________________________Date:___________________

## AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

1.) Alaska Bariatric may disclose my health information to: ________________________________________
Relationship: _________________________

This authorization is effective from ____/____/____ to ____/____/____and includes only personal health information pertaining to Alaska Bariatric Center and its providers.

2.) Alaska Bariatric may disclose my health information to: ________________________________________
Relationship: _________________________

This authorization is effective from ____/____/____ to ____/____/____and includes only personal health information pertaining to Alaska Bariatric Center and its providers.

## HIPAA AGREEMENT FORM

The Alaska Bariatric Center's **Notice of Privacy Practices** is available for your review either via our website (www.alaskabariatric.com) or our Facebook page. The Notice of Privacy Practices provides a detailed description of what we do with health and personal information that we have about you. It also explains your rights, as a patient, for getting access to that information and controlling its use and disclosure.

I understand that I have been offered a copy of the Alaska Bariatric Center's Notice of Privacy Practices.

Signature of Responsible Party: ______________________________________________________Date:___________________

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## BILLING FORMS

## NOTIFICATION OF NON-COVERAGE OR POSSIBLE NON-COVERAGE

- Telephone Visit *(99441-99443)*
    - Due to the Pandemic, most insurance companies are covering these visits with applicable copay. This includes Medicare, Medicaid and Tricare. However, this may change at any time. We encourage patients to verify with their insurance company for coverage and restrictions.
- Insurance Lifetime Maximum
    - It is possible for a covered procedure to have a lifetime maximum payable amount. In these cases, the patient is responsible for the remaining balance. We encourage patients to verify with their insurance company for coverage and benefits to avoid unforeseen patient expenses.
- Usual and Customary
    - Insurance companies have set allowable amount. If a patient's insurance company is not contracted with our office, the patient is responsible for any difference between insurance allowable and charges accrued.

**PLEASE SIGN BELOW AFTER READING THE ABOVE INFORMATION. YOUR SIGNATURE ACKNOWLEDGES THAT YOU ARE AWARE THAT THESE SERVICES MAY OR MAY NOT BE COVERED BY YOUR INSURANCE AND THAT YOU ARE RESPONSIBLE FOR PAYMENT.**

Signature: ______________________________ Date:______________

Printed Name: ______________________________

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## PATIENT NOTICE OF BILLING PRACTICES

***PLEASE READ, INITIAL WHERE INDICATED, AND SIGN BELOW.***

Payments for medical services provided by Alaska Bariatric Center is due at the time of service. We accept cash, most credit cards, personal checks, and money orders. Payment in full at time of service is required when:

- You do not have insurance coverage
- You have not brought your insurance card(s) with you.
- You have not met your deductible.
- A referral or prior authorization was not obtained.
- Any procedures or treatments we believe are not covered by insurance.

Patient responsibility:

(Initial)

____ Insurance coverage is not a guarantee of payment.

____ We will bill your insurance company as a courtesy, if you present your insurance card(s) at the time of your appointment.

____ Any co-payments or “patient responsibility” must be paid at the time of service.

____ Any remaining balance, after all applicable insurance payments have been applied, is due upon receipt of billing statement.

____ Prior to receiving a surgery date, your account balance must be paid in full.

____ If payment in full is not received within 90 days from the date of the first statement, your account may be turned over to cornerstone credit services.

____ Cancelled appointments require 24 hours’ notice; otherwise they will be subject to a $25 charge.

____ If we do not receive response from your insurance company within 45 days from the date we bill them, then the balance will become patient responsibility.

We also recommend that you research your insurance benefits prior to your office visit, as there could be reasons why your insurance may not pay for your visit. These reasons may include, but are not limited to:

- Your deductible has not been met.
- You have not received the proper referral or preauthorization for the visit or procedure.
- The services or procedures are not covered by your insurance company. *We will inform you when we know a treatment/procedure will not be covered. Some insurance policies have exclusions for bariatric surgery. If there is any uncertainty about coverage, we would be happy to provide you with an estimate of your fees prior to treatment. You are responsible for all non-covered services at the time of your visit.*

We may choose to use an independent laboratory. If so, this lab will bill separately for these services. We will provide your insurance information to the lab so that they may file a claim with your carrier. The lab will then bill you for any remaining balance. You will need to contact them directly for any questions regarding their bill. This also applies to any other testing we may order for you that is performed by another provider.

*By signing my signature below, I acknowledge that I have read and that I understand the above statements and am willing to accept responsibility to pay for services rendered if my insurance does not cover them*

Signature: ______________________________ Date: ______________

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# MEDICAL HISTORY QUESTIONNAIRE

By filling out this very detailed personal questionnaire, we can cut down the time you have to spend in our office. This information will also help us to take better care of you.

## PERSONAL INFORMATION

Full Name (First, Middle, Last): ________________________________________________

Race: ☐African American ☐Caucasian ☐Native American or Alaska Native ☐Asian ☐Hispanic ☐Native Hawaiian or Other Pacific Islander

Other: ____________________________________

I was referred by: ______________________________________________________

What is your occupation? ________________________________________________

Are you married? Y or N Do you have children? Y or N *If so, how many? ____________

Who do you live with? ___________________________________________________

Do you decline blood products? Y or N If yes, please explain:

______________________________________________________________________

## INFORMATION ABOUT YOUR OTHER HEALTHCARE PROVIDERS

My regular doctor is Dr. _____________________________

Specialty: ____________________________________

Address: ___________________________ City: _________________ State: _____ Zip:____________

Phone: _______________Fax: _______________E-mail: (optional):___________________________

Second doctor/therapist to send a report to is Dr.__________________________

Specialty: ____________________________________

Address: ___________________________ City: _________________ State: _____ Zip:____________

Phone: _______________Fax: _______________E-mail: (optional):___________________________

Third doctor/therapist to send a report to is Dr.________________________

Specialty: ____________________________________

Address: ___________________________ City: _________________ State: _____ Zip:____________

Phone: _______________Fax: _______________E-mail: (optional):___________________________

## PERSONAL WEIGHT HISTORY

Please list your current: Weight _________ Height __________ Age __________

At what age did you begin to have weight problems? ______

What has been your highest weight to date? ______________________________________________

How much did you weigh when you graduated from high school/turned 18? ______________

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## FAMILY WEIGHT HISTORY

**Please tell us about your parents, siblings, children, and spouse; and whether or not they have weight problems.**

**Ex: Father has had weight issues since the age of 25.**

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
__________________________________________________________________________

## FAMILY MEDICAL HISTORY

**Does anyone in your family have problems with bleeding, anesthesia, or blood clots in the legs?**
**Ex: Bloods clots on maternal side.**

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
_________________________________________________________________________

Have you had any recent (circle any that apply)

| | | |
|---|---|---|
| Cough | Diarrhea | Fever |
| Sore Throat | Constipation | Chills |
| Other Chest Pain | Burning urination | Night Sweats |

## WEIGHT LOSS HISTORY

**Please list all of the attempts you have made, including diets, exercise programs, and medications either with organized programs or on your own at home. Please give the approximate date of the attempt, how long you tried it, how much weight you lost, and how much you regained, if any. Please note if a physician or other health care provider supervised the attempt, or if you were part of an organized program at a gym or health club.**

**Must have a minimum of 3 attempts for insurance purposes documented on the following table.**

| PROGRAM | WHEN | HOW LONG | WEIGHT LOSS | WT. REGAINED | SUPERVISED |
|---|---|---|---|---|---|
| Ex: Atkins | 2000 | 12months | 30lbs | 40s | Self |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

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## MEDICAL HISTORY

**Please circle here if you have, or have had:**

High Blood Pressure/Hypertension
Heart Attack
Heart Failure
Other Heart Disease

Cushing's Disease
Stomach or Duodenal Ulcer
Gout

Asthma
Chronic Bronchitis
Other Lung Disease

Diabetes
Hypercholesterolemia
Borderline Diabetes
Diabetes during pregnancy

Depression
Gallbladder Disease
Hypothyroidism
Thyroid Problems
Hypertriglyceridemia
History of Blood Clots (legs or lungs)
Hiatal Hernia

Other Health Issues:

______________________________________________________________________

______________________________________________________________________

## MEDICAITONS

Please list ANY medications or supplements you may take including over-the-counter ones such as aspirin, vitamins, or herbal preparations: (attach list of medications if not enough room)

| MEDICATION | REASONS TAKEN | DOSAGE | FREQUENCY |
|---|---|---|---|
| Ex. Metformin | Diabetes | 500 mg | Twice Daily |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Have you taken any kind of steroids (oral, injections, inhalers) during the past year? Y or N

If yes, please explain: ______________________________________________________________

______________________________________________________________________

Medication or food allergies, and the reaction you have to them:

Ex: Penicillin = rash, swelling.

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

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## SURGERIES

*Please circle here if you have had prior weight loss/bariatric surgery* Y or N

Please list all of the operations you have had, including dates of service.

| Surgery | Date, Hospital, Surgeon |
| --- | --- |
| Ex: Gallbladder | 2003, Alaska Regional Hospital, Dr. No Name |

______________________________________________

______________________________________________

______________________________________________

______________________________________________

## HABITS

Do you use Tobacco Products? Y or N if yes, please explain:

______________________________________________

Do you use recreational drugs? Y or N if yes, please explain:

______________________________________________

Do you drink alcoholic beverages? Y or N if yes, please explain:

______________________________________________

Do you drink caffeinated beverages? Y or N if yes, please explain:

______________________________________________

## ADDITIONAL MEDICAL INFORMATION YOU FEEL OUR OFFICE MAY NEED:

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

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______________________________________________

______________________________________________

______________________________________________

______________________________________________

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## WEIGHT RELATED PROBLEMS

Please circle all that apply.

- Frequent
  - Indigestion
  - Abdominal gas
  - Belching (burping)
- Burp up sour tasting liquid
- Pain behind breastbone or heartburn
- Swallowed foods sticking in your throat
- Hemorrhoid problems
- Frequent diarrhea
- Frequent constipation
- Abdominal hernia
- Wake with severe headaches
- Become short of breath when
  - Climbing a flight of stairs
  - Climbing half a flight of stairs
  - Crossing a parking lot
- Have occasional severe headaches
- Use a wheelchair
- Are you disabled? ____

- Aches and pains in
  - Back
  - Neck
  - Hips
  - Thighs
  - Knees
  - Legs
  - Ankles
  - Feet
- Difficulty walking
- Swelling of legs, feet, or ankles
- Lose urine with cough or strain
- Racing heart beat
- Frequent numbness of feet or legs
- Abnormal hair growth
- Rashes or infections in skin fold
- Skin aches
- Heavy, frequent, irregular. painful menstruation
- Fertility problems

## LIFESTYLE PROBLEMS

Do you have problems with any of the following? If so, please circle them and tell us a little about how much of a problem they are; such as if you can't do something, or if you can only do it with help. These may raise uncomfortable feelings, but they help us document non-medical ways that Morbid Obesity may affect your life.

- Aircraft seating
- Movie seating
- Restaurant booths
- Turn styles
- Dressing
- Putting on socks and shoes
- Looking at yourself in the mirror
- Being seen in public
- Being seen with your family
- Difficulty keeping up on outings
- Playing with your children or pets
- Intimate relations

- Walking on uneven ground
- Walking outside on ice or snow
- Staying inside during the winter for long periods of time because you do not feel safe walking on ice and snow
- Problems reaching (high or low)
- Cleaning after going to the bathroom
- Showering yourself
- Need to take multiple showers every day
- Controlling body odor

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## SLEEP RELATED PROBLEMS

Do you have diagnosed obstructive sleep apnea? Y or N

If NO please fill out the following:

How many pillows do you sleep with? ______

How many times do you wake at night? ______

Read the following situations and use the scale provided to rate your sleepiness.

**0= would never dose** **1= slight chance of dozing**

**2= moderate chance of dozing** **3=high chance of dozing**

| | | | | |
|---|---|---|---|---|
| Sitting and Reading | 0 | 1 | 2 | 3 |
| Watching TV | 0 | 1 | 2 | 3 |
| Sitting Inactive in a public place | 0 | 1 | 2 | 3 |
| Laying down to rest in the afternoon | 0 | 1 | 2 | 3 |
| As a passenger in a car for one hour without a break | 0 | 1 | 2 | 3 |
| Sitting quietly after lunch (without alcohol) | 0 | 1 | 2 | 3 |
| In a car, stopped for a few minutes in traffic | 0 | 1 | 2 | 3 |

Check boxes that apply:

- ☐ Someone has observed me stop breathing during my sleep.
- ☐ Have you been told you snore loudly
- ☐ Sleep better on a chair or sofa
- ☐ Awaken with feelings of dread/breathless
- ☐ Wake up as tired as when going to bed
- ☐ Fall asleep while driving, talking, working
- ☐ Wake with severe headaches
- ☐ I snore.
- ☐ I often feel tired, fatigued, or sleepy throughout the day.
- ☐ I have or am being treated for high blood pressure.
- ☐ My BMI is 35 or greater.
- ☐ I am 50 or older.
- ☐ My neck circumference is greater than 40cm (15.75 inches)
- ☐ I am male