## Patient Information Sheet

| | | | | |
|---|---|---|---|---|
| Seminar: | Office Visit: | | Surgical Date: | **RNY/BAND/SLEEVE** |
| Name:<br>Nombre: | | | Primary Physician:<br>Medico Primario: | |
| Address:<br>Direccion: | | | Physician Phone:<br>Telefono Medico: | |
| City, Zipcode:<br>Cuidad, Zipcode: | | | Physician Fax: | |
| Preferred Phone #<br>Numero Preferrido | | | Alternate Phone #<br>Nuemero Alternativo | |
| DOB:<br>Fecha de nacimiento: | Age:<br>Edad: | Sex: M / F<br>Sexo: | Marital Status:<br>Estado Matrimonial: | SS#<br>Seguro Social - |
| Email Address:<br>Coreo Electronico: | | | | |
| Occupation:<br>Occupacion: | | Employer:<br>Empleado: | | Business Phone:<br>Telefono: |
| Primary Ins. Co:<br>Seguro Primario: | | | Secondary Ins. Co:<br>Seguro Secondario: | |
| Policy #:<br>Polisa de seguro: | | | Policy #:<br>Polisa de seguro: | |

### *CONSULTS – FOR OFFICE USE*

| | |
|---|---|
| Cardio | |
| Pulmonary | |
| GI | |
| Psych | |
| Nutrition | |
| PCP / Other | |

***Please sign required signature line – We will discuss with you if any questions***

**Solo para pacientes de Medicare / Medicare Patients Only:** "I request that payment of authorized Medicare benefits be made either to me or on my behalf to Stafford Surgical Specialists / Monmouth Surgical Specialists / Montclair Surgical Associates (SSS/MSS/MSA) for any services rendered to me by the physicians of SSS/MSS/MSA. I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA) and its agents any information needed to determine these benefits payable for related services.

Signature / Firma _____Date / Fecha _____

**Pacientes que no son de Medicare / Non-Medicare Patients:** I request that payment of authorized benefits be made either to me or on my behalf to Stafford Surgical Specialists / Monmouth Surgical Specialists / Montclair Surgical Associates (SSS/MSS/MSA) for any services rendered to me by the physicians of SSS/MSS/MSA. I authorize any holder of medical information about me to release to my insurer and its agents any information needed to determine these benefits of the benefits payable for related services.

Signature / Firma _____Date / Fecha _____

**Surgical Assistant Policy / Cirujano Asistente**

Only the operating surgeon can decide if an assistant surgeon is required for the proper conduct of an operation. Some insurance plans do not cover the services of an assistant surgeon, even when requested by the operating surgeon with the patient's best interest and safety in mind. Please be advised that in such cases you will be billed directly for the assistant's services. The usual and customary fee for the assistant is 25% of the surgeon's fee. We are happy to discuss this policy with you if there are any questions. Your signature affirms that you have read this policy.

Signature / Firma _____Date / Fecha _____

**ASSIGNMENT OF BENEFITS/DESIGNATED AUTHORIZED REPRESENTATIVE/LIMITED SPECIAL POWER OF ATTORNEY**

It is our policy, for your convenience, as well as to facilitate payment, to file health benefit claims on your behalf. To enable your insurance policy or benefit plan to deal with us directly, please read the following, sign and print your name below and enter today's date.

Assignment of Benefits

I hereby assign and convey to the fullest extent permitted by law any and all benefit and non-benefit rights (including the right to any penalties or equitable relief) under my health insurance policy or benefit plan to Monmouth Surgical Specialists and Dr. Karl Strom, Dr. Silvia Fresco, Dr. Jonathan Reich, Dr. Juan Lujan, Dr. Marius Calin, Dr. Robert Barbalindo, Dr. James Nangeroni, Dr. Kevin Bain, Dr. Richard Greco (collectively, the "Providers") with respect to any and all medical/facility services provided by the Providers to me for all dates of service, including without limitation, the right of one or more of the Providers, or their attorney (or other representative) to (i) execute, in my name and on my behalf, any form, document or instrument required under any applicable insurance policy or benefit plan to further evidence my intent as set forth herein and to avoid any delay in pursuing rights under applicable Federal and State laws, rules, regulations or requirements (collectively, "Laws"), (ii) pursue penalties for and exclusively on behalf of Providers against any insurance policy or benefit plan for failure of the plan administrator (or other fiduciary) to timely produce or respond to requests (including appeals) for all information relating to any plan documents as required by any applicable Laws, (iii) to assert claims and initiate legal action for breach of fiduciary duty against any person or entity, and (iv) to endorse for me any checks made payable to me for benefits and claims collected toward my account.

In the event the insurance carrier responsible for making medical payments to Monmouth Surgical Specialists and Dr. Karl Strom, Dr. Silvia Fresco, Dr. Jonathan Reich, Dr. Juan Lujan, Dr. Marius Calin, Dr. Robert Barbalindo, Dr. James Nangeroni, Dr. Kevin Bain, Dr. Richard Greco for medical services rendered to me does not accept my assignment of benefit rights, or my assignment is challenged or deemed invalid, I execute this limited/ special power of attorney and appoint and authorize Provider and his/her/its attorney (or other representative) as my agent and attorney, in fact, to assert any and all of my benefit and non-benefit rights for and on my behalf, including, without limitation, to bring any appeal, pre-litigation demand, demand for payment, arbitration, lawsuit, independent dispute resolution or administrative proceeding, for and on my behalf, in my name against any person and/or entity involved in the determination and payment of benefits under any insurance policy or benefit plan. I agree that any recovery shall be applied to payment due my provider including attorney fees and costs. To this end, Provider has exclusive settlement authority.

Designated Authorized Representative

I hereby appoint as a Designated Authorized Representative each of my Providers and each of their respective assistant surgeons, physician assistants, teaching assistants, billing staff, lawyers (including Cohen Howard, LLP) or any other person or business that provides healthcare activity services as a "business associate' under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), and their respective designees (collectively referred to herein as an "Authorized Representative"). This authorization is intended to comply with all requirements of the Employment Retirement Income Security Act of 1974, as amended (ERISA") and any applicable State law. Each Authorized Representative is granted the same rights which I have as a member or beneficiary under my insurance policy or benefit plan, including without limitation:

1. The right of my Authorized Representative to file claims for benefits on my behalf and directly receive payment for benefits and non-benefits under my insurance policy or benefit plan, including the right to penalties, interest and attorney fees.
2. The right of my Authorized Representative to communicate with insurers, plan fiduciaries, employers and plan and claim administrators relative to all my benefit information and protected health information ("PHI" as further defined under HIPAA) and to share and exchange such information with a "covered person" or "business associate" as those terms are defined under HIPAA.
3. The right of my Authorized Representative to send and receive follow-up information and obtain all documentation that ERISA or any State law requires to be provided to me, including, without limitation, plan documents, explanation of benefits, adverse benefit determinations, all relevant documents involving my claim, identity of all persons involved in determining my claim and all documents relied upon in making any determination as to the payment of any amount under the applicable plan documents.
4. The right of my Authorized Representative to file any internal or external member appeal for payment of benefits under any applicable insurance policy or benefit plan.
5. The right of my Authorized Representative to pursue any rights, claim or cause of action through pre-litigation demands, demands for payment, arbitration, independent dispute resolution or administrative proceeding, litigation or otherwise under any Federal or State law with respect to payment for services provided by a Provider to me, including penalties, interest and attorney fees.

Release of Private Health Information

It is specifically intended that any Provider or Authorized Representative is authorized and directed to provide and release my PHI for purposes of exercising all rights and benefits set forth in this Assignment of Benefits/Designated Authorized Representative authorization to any "covered person" or "business associate", including third-party payors, internal and external utilization review organizations, regulatory review entities and other organizations and/or companies that may/will assist with claims processing/reimbursement. I also direct any plan or claim administrator or plan sponsor to share all PHI with any Provider or Authorized Representative and not to inhibit the exercise of rights under my insurance policy or benefit plan by requiring any further authorization signed by me.

I understand that I remain fully responsible for any billed charges remaining due for services provided to me by a Provider, including co-pays, co-insurance and deductibles. If I receive any check or other payment from an insurance company or third-party payor for services rendered to me by a Provider, I will immediately endorse the check over to the Provider or otherwise make payment to the Provider for the amount of payment received from such insurance company or third-party payor. I agree that if the Provider is required to pursue collection efforts against me for these amounts, I will be responsible for all legal fees, interest and costs associated therewith.

This Assignment of Benefits/Designated Authorized Representative authorization/ Limited Special Power of Attorney shall remain in full force and effect for all current and future dates of service, until such time that all rights have been exercised under applicable Federal and State law as determined by Providers. I may revoke or withdraw this authority upon written notice to the Providers. In the event of any revocation, I will be responsible for payment of all outstanding amounts then due to the Providers.

Patient Name:_____ Date:_____

Patient Signature: _____

Revised 4/2026

**Acknowledgement of HIPAA privacy notice and designation of disclosure**

## *Privacidad*

Patient Name: _____ Date of Birth:_____

I wish to be contacted in the following manner (check all that apply):

Telephone, Written and Fax Communication

**Home/Cell Telephone Number**:

_____

___Ok to leave a message with detailed information – **Dejar mensaje**

**Written Communication:**

__Ok to mail to my home address that I listed on registration.- **Enviar por correo**

Other:_____

**Designation of Certain Relatives, Close Friends and Other Caregivers**: **Familia/amistad**

I agree that the practice may disclose certain health information to a family member, close personal friend or other caregiver, since such person is involved with my health care or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my healthcare.

I designate the following persons listed below as persons involved with my healthcare or payment relating to my healthcare for the purpose of practice making limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.

Print Name:_____ Relationship:_____
Print Name:_____ Relationship:_____
Print Name:_____ Relationship:_____
Print Name:_____ Relationship:_____

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my health care, the Physician's Practice originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as: *A basis for planning my care and treatment. *A means of communication among the many health professionals who contribute to my care. *A source of information for applying my diagnosis and surgical information to my bill. *A means by which a third-party payer can verify that services billed were actually provided, and I understand that I have the following rights and privileges: The right to review the notice prior to signing this consent.

I understand that the Physician's Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that the Physician's Practice reserves the right to change their notice and practices prior to implementation, in accordance with Section 164-520 of the Code of Federal Regulations. I wish to have the following restrictions to the use or disclosure of my health information.

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and **accept/decline** (**circle one**) the terms of this consent.

I have been presented with and understand the Physician's Practice Notice of Privacy Policy.

Email Address _____ ☐ Check box if ok to use email as a method of contact

Signature of Patient/Parent/Guardian:_____Date: _____

# Medication Log and Co-Morbidity
# Lista de Medicamentos

**Patient's Name:**_____ **DOB:**_____

| **ALLERGIES: Alergias** | | | | |
|---|---|---|---|---|
| **List of Medications:**<br>******Please Include Over the Counter Medications****** | | | | |
| Name:<br>Nombre | Dose<br>Dosis | Frequency<br>Frequencia | Duration | Reason for Taking |
| | | | | |
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| ☐ **NSAID warning given** | | | | |
| Sleep Apnea- Apnea de sueno | ☐ CPAP | | ☐ BiPAP | |
| Oxygen- Oxigeno | ☐ 24 hours | | ☐ During Sleep | |

****** Please review list. Write current date and your initials.******

| | | | |
|---|---|---|---|
| | | | |
| | | | |
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**OFFICE USE ONLY:** List of Co-Morbidities:

| | | |
|---|---|---|
| | | |
| | | |
| | | |

Date_____Pre-Op Patient Assessment Questionnaire

| | | | | |
|---|---|---|---|---|
| Name | | Last | | |
| DOB | Age | ☐Female ☐Male | | |
| ☐Gastric Bypass ☐LapBand ☐ Sleeve ☐Don't Know | | | | |
| Allergies /Reaction: | | | | |
| **Medications you are currently taking: See attached Medication Log** | | | | |
| **Do you have:** | | | | |
| ☐Arthritis - Artritis | ☐Fibroids - Fribroma | ☐Joint pain or swelling | | |
| ☐Angina - Angina | ☐GERD reflux disease – Gastroesofagio | ☐Lupus- | | |
| ☐Asthma | ☐Gallbladder disease-Vesicula biliar | ☐Ovarian Cysts-quiste ovario | | |
| ☐Blood Clots- Coagulo Sangre | ☐Glaucoma | ☐Peptic Ulcer Disease | | |
| ☐Bleeding Problems Problemas de sangrar | ☐Hypertension - Hipertension | ☐Stroke-Cerebrovasvular | | |
| ☐BPH, prostate disease | ☐Heart Attack – Ataque Cardiotico | ☐Shortness of Breath | | |
| ☐Congestive Heart Failure Cardiaca Congestiva | ☐High Cholesterol (>200) - Colesterol | ☐Sleep Apnea- Sueno Apnea | | |
| ☐Coronary Disease- | ☐Hypoventilation Syndrome (pCO2>45 or hemoglobin) | ☐CPAP ☐BIPAP | | |
| ☐Colitis | ☐Hypothyroid-Hipotiroidismo | ☐Snoring-ronquidos | | |
| ☐Cataracts | ☐Hepatitis | ☐Skin Disease | | |
| ☐Cancer Tumors If yes, what type | ☐Idiopathic Intracranial Hypertension Pseudotumor Cerebri | ☐ Sexually transmitted disease When _____ Type _____ | | |
| ☐Diabetes | ☐Infertility - Esterilidad | | | |
| ☐Diverticulitis | ☐Incontinence bladder/bowel | ☐Venous Stasis | | |
| ☐Depression | ☐Irregular Periods/Last period: | ☐Other | | |
| ☐Emphysema | If post-menopausal, since what date: | | | |

**Please List all prior surgeries/hospitalizations/injuries – *Lista de Operaciones***

| Operation | Date | Hospital | Surgeon | Any problems |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

| Did you have general anesthesia? ☐No ☐Yes | Problems? Con anesthesia ☐No ☐Yes |
|---|---|

**Family history Check family members who have had any of the following problems**

| Obesity- Obesidad | Mother | Father | Maternal Grandmother | Maternal Grandfather | Paternal Grandmother | Brother | Sister | Other |
|---|---|---|---|---|---|---|---|---|
| Heart Disease | | | | | | | | |
| Stroke | | | | | | | | |
| Diabetes | | | | | | | | |
| High Blood Pressure | | | | | | | | |
| Sleep Apnea | | | | | | | | |
| Bleeding | | | | | | | | |
| Cancer | | | | | | | | |

**Social History**

| Do you smoke? ☐No ☐Yes – If Yes, how much? Packs per day. -Fuma | |
|---|---|
| Do you drink alcohol?- ☐No ☐Yes – If Yes, how much? | How long ago did you quit? |
| Do you use recreational drugs?- Usa drogas ☐No ☐Yes – If Yes, what type and how much? | |
| What kind of work do you do? | |
| Do you plan a pregnancy in the next two years? ☐No ☐Yes | |

**To what degree do you feel that weight affects your life (1=minimal affect, 5=severe)**

| | 1 | 2 | 3 | 4 | 5 | Comments |
|---|---|---|---|---|---|---|
| Self Esteem- Autoestima | | | | | | |
| Physical Activity- Actividad | | | | | | |
| Socially Involved- eres sociable | | | | | | |
| Able to Work- trabajar | | | | | | |
| Interested in Sex- sexo | | | | | | |
| Financial Well Being | | | | | | |
| Participates in Recreation | | | | | | |

**Please answer the following regarding your attempts to lose weight**

| How long have you been over weight?<br>Cuanto tiempo estas sobre peso? | What was your weight at age 18?<br>Cuanto pesavas cuando tenia 18 anos? |
|---|---|
| Lowest adult weight in the past 5 years<br>En 5 anos cuanto tenia bajo peso? | Highest adult weight in the past 5 years<br>Mas peso alto en 5 anos? |
| What was the biggest loss in pounds you had?<br>Cuanto peso perdiste bastante? | How long did it take you to lose the weight?<br>Cuanto tiempo te tomastes? |
| Did you regain this weight ☐No ☐Yes | How long did it take you to regain the weight? |

**What kind of exercise are you doing currently? Ejercisios?**

| ☐Treadmill- rueda de andar | ☐Jogging - Correr |
|---|---|
| ☐Walking - Camina | ☐Personal Trainer- Entrenador Privado |
| ☐Swimming- Nadas | ☐Aerobics |

| | |
|---|---|
| ☐Wt. Training- usas pesas | ☐VHS/DVD |
| ☐Bicycle- Bicicleta | ☐Other |

| **How were you referred to the Center for Bariatrics?** | |
|---|---|
| Physician: | Previous Patient: |
| Friend/Family Member: | Newspaper Ad: |
| TV/Radio: | Internet/Website: |
| Other: | Other: |

| | Name | Phone | Fax | Town |
|---|---|---|---|---|
| Primary MD | | | | |
| Gastro | | | | |
| Cardiac | | | | |
| Pulmonary | | | | |
| Endocrine | | | | |
| Psych | | | | |
| Dietitian | | | | |
| OB/GYN | | | | |

Patient Name _____Pre-Op Patient Assessment Questionnaire

| **Weight Loss History – que has hecho para perder peso** | | | | |
|---|---|---|---|---|
| Insurance companies request the following information. | | | | |
| Programs | Dates (mm/yyyy) | Duration | MD Supervised | Amount of Weight Loss |
| Weight Watchers | | | | |
| Keto | | | | |
| Whole 30 | | | | |
| Slimfast | | | | |
| Jenny Craig | | | | |
| Intermittent fasting | | | | |
| Nutrisystem | | | | |
| Optifast | | | | |

| | | | | |
|---|---|---|---|---|
| Isogenix | | | | |
| Mediterranean | | | | |
| DASH | | | | |
| Atkin's Diet | | | | |
| South Beach Diet | | | | |
| Health Spas | | | | |
| Gym/Exercise Program | | | | |
| Contrave | | | | |
| Saxenda | | | | |
| Medication - Non prescribed | | | | |
| Weight Loss Medication<br>Medicamento para perder peso | | | | |
| Medically Supervised Diets | | | | |
| Others | | | | |
| | | | | |

If you have surgery. How much weight do you expect to lose? Cuanto crees perder con la surugia?

Did you attend our weight loss seminar? If yes, when?