NEW PATIENT REGISTRATION FORM

VENICE METABOLIC AND BARIATRIC SURGERY

LAST NAME	FIRST NAME	MIDDLE	PREFERRED NAME
ADDRESS		CITY, STATE, ZIP	
MAILING ADDRRESS (IF DIFFERENT FROM ABOVE)		CITY, STATE, ZIP	
EMAIL ADDRESS			

HOME PHONE	CELL PHONE	WORK PHONE
BIRTH DATE	SEX	SSN
EMERGENCY CONTACT NAME	RELATIONSHIP	CONTACT NUMBER
EMPLOYMENT STATUS	EMPLOYER NAME	EMPLOYER ADDRESS

PHYSICIAN INFORMATION

PRIMARY CARE PROVIDER	PCP PHONE NUMBER
REFERING PROVIDER	

AUTHORIZATION

It is our responsibility to protect your medical records and we do not provide any information regarding you or your medical conditions without your written consent. Please list below any whom we may discuss your medical conditions as well as any medical billing issues.

NAME	RELATIONSHIP	CAN DISCUSS MY:
NAME	RELATIONSHIP	CAN DISCUSS MY:
NAME	RELATIONSHIP	CAN DISCUSS MY:

PHONE CALL MESSAGES

We often call patients for the reasons listed below. Please mark which number we may call to leave messages.

Is it okay to leave a message to confirm your appointment?

☐ Home ☐ Cell ☐ No, do not call to leave a message at the home or cell number

Is it okay to leave a message with results of lab or imaging studies?

☐ Home ☐ Cell ☐ No, do not call to leave a message at the home or cell number

Is it okay to mail the results of lab or imagaing studies to your home address?

☐ Home ☐ Cell ☐ No, do not call to leave a message at the home or cell number

INSURANCE

Who is to be billed for today's visit?

☐ INSURANCE ☐ SELF

PRIMARY INSURANCE

INSURANCE COMPANY NAME	POLICY NUMBER	RELATIONSHIP TO INSURED
SUBSCRIBER NAME	SUBSCRIBER SEX	SUBSCRIBER DATE OF BORTH
INSURANCE BILLING ADDRESS(Usually located on back of card)	INSURANCE PHONE NUMBER	
GROUP EMPLOYER NAME	GROUP NUMBER	

SECONDARY INSURANCE

INSURANCE COMPANY NAME	POLICY NUMBER	GROUP NUMBER
SUBSCRIBER NAME	SUBSCRIBER SEX	SUBSCRIBER DATE OF BORTH
INSURANCE BILLING ADDRESS (Usually on back of the card)	INSURANCE PHONE NUMBER	
GROUP EMPLOYER NAME	GROUP NUMBER	

ADDITIONAL DEMOGRAPHIC INFORMATION

PRIMARY LANGUAGE

SPOKEN:
- ☐ ENGLISH
- ☐ SPANISH
- ☐ INDIAN
- ☐ RUSSIAN
- ☐ OTHER:_____

WRITTEN:
- ☐ ENGLISH
- ☐ SPANISH
- ☐ INDIAN
- ☐ RUSSIAN
- ☐ OTHER:_____

RACE
- ☐ AMERICAN INDIAN OR ALASKAN NATIVE
- ☐ ASIAN
- ☐ AFRICAN AMERICAN
- ☐ HISPANIC OR LATINO
- ☐ CAUCASIAN
- ☐ PREFER NOT TO DISCLOSE

ETHNICITY
- ☐ HISPANIC
- ☐ NON-HISPANIC
- ☐ PREFER NOT TO DISCLOSE

HOW DID YOU HEAR ABOUT US?
- ☐ PERSONAL REFERENCE (FRIEND, FAMILY OR ANOTHER PATIENT)
- ☐ INSURANCE COMPANY
- ☐ BILLBOARD
- ☐ NEWSPAPER AD
- ☐ INTERNET
- ☐ MEDICAL PROVIDER
- ☐ OTHER

INITIAL EVALUATION FORM

Venice Metabolic and Bariatric Surgery

1370 E. Venice Ave. Suite 208

Venice, FL 34285

Phone: 941-209-4646

Fax: 941-445-4152

The following information is very important to your health. Please take time to fully and completely fill out this important information. We are counting on you.

Date: _____

Name: _____ Date of Birth_____ Age: _____

Home Phone: _____Work Phone: _____

Cell Phone: _____

Email Address: _____

Height_____ Weight_____ Sex_____

Primary Care Physician: _____

What is your primary reason for making an appointment? _____

Are you seeking evaluation for weight loss surgery for morbid obesity? _____

At what age did you develop a significant weight problem? _____

Are there events that are related to your weight gain? If so, what are they? _____

_____

Have you ever received treatment to lose weight? Yes No

If yes, when and where? _____

_____

Do you use supplements or medications for appetite control? Yes No

If yes, list any medications, vitamin, mineral, nutritional supplements or appetite control drugs you currently use or used: _____

Are you on a restricted or special diet for any medical reasons? Yes No

If yes, please explain: _____

The above is true and correct to the best of my belief _____

Patient Signature

Record major diets that resulted in weight loss of 10 pounds or more. (Use additional pages as needed.)

Year	Length of diet	Starting weight	# of pounds lost	Length of time weight stayed off	Type of diet program

~~~~~~

Do you snore? **Yes** **No**

Do you ever wake at night gasping for breath? **Yes** **No**

Has anyone ever told you that you stop breathing while asleep? **Yes** **No**

Is it hard to fall asleep? **Yes** **No**

~~~~~~

Are you currently being treated for depression? **Yes** **No**

Have you ever been treated for depression? **Yes** **No**

If yes to either, name of Psychiatrist or mental health provider? _________________________________

Do you feel sad most of the time? **Yes** **No**

Do you have or have you been treated for an eating disorder? **Yes** **No**

Has your appetite changed over the past six months? **Yes** **No**

Has your interest in sex changed over the past six months? **Yes** **No**

~~~~~~

Do you exercise regularly? **Yes** **No**

If so, what type of exercise do you preform? ____

How many times a week do you exercise? ____

How long do you exercise each time? ____

In your opinion, what contributes to your excess weight?

Compulsive Eating **Eating too much fat/sugar** **Nervous Eating** **Stress**

Lack of Exercise **Lack of Knowledge** **Emotional Eating** **Portion Sizes**

The above is true and correct to the best of my belief ____

Patient Signature
~~~~~~

Have you or one of your relatives ever had bariatric surgery? Yes No

(*Weight reduction surgery*)

If yes, what relationship are they to you? ____

If yes, what type of procedure was performed? ____

If yes, which doctor performed the surgery? ____

~~~~~~

ALLERGY INFORMATION

Please list any known allergies.

1.) _____________________________ what type of reaction did you have? _________________________
2.) _____________________________ what type of reaction did you have? _________________________
3.) _____________________________ what type of reaction did you have? _________________________
4.) _____________________________ what type of reaction did you have? _________________________
5.) _____________________________ what type of reaction did you have? _________________________

MEDICAL INFORMATION

Please list all prescribed and over the counter medications, vitamins and minerals that you are currently using:

	Medication	Dose	Times per day	Year started	Purpose
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					

The above is true to the best of my belief ____

Patient Signature
~~~~~~

Pharmacy Information

Name of Pharmacy: _____ Phone Number: _____

Address: _____

Surgical Information

Part I. Please list any surgical procedure, reason and year. If relevant, please specify if the surgery was performed laparoscopic or open.

Type of Surgery _____ Reason_____ Year _____

Type of Surgery _____ Reason_____ Year _____

Type of Surgery _____ Reason_____ Year _____

Type of Surgery _____ Reason_____ Year _____

Type of Surgery _____ Reason_____ Year _____

Type of Surgery _____ Reason_____ Year _____

Type of Surgery _____ Reason_____ Year _____

Type of Surgery _____ Reason_____ Year _____

Part II. For FEMALE patients only:

1. **Have you ever had a hysterectomy? Yes No**
   - **If yes, please indicate: Vaginal Abdominal**
   - **If yes, please indicate year: _____**
   - **If yes, were ovaries removed? Yes No**
2. **Have you ever had a Cesarean Section? Yes No**
   - **If yes, please indicate how many: _____**
   - **If yes, please indicate the year: _____**
3. **Have you ever had a tubal ligation? Yes No**
   - **If yes, please indicate how the procedure was performed: Open Laparoscopic**

The above is true to the best of my belief _____

Patient Signature

MEDICAL HEALTH INFORMATION

Please indicate if any of the following conditions have ever been significant problems for you. Please specify the year diagnosed and the physician who currently manages the problem.

CARDIAC:

Coronary Artery Disease **Yes** **No**

Year Diagnosed _____ Physician _____

MI (Heart Attack) **Yes** **No**

Year Diagnosed _____ Physician _____

Elevated Cholesterol **Yes** **No**

Year Diagnosed _____ Physician _____

Chest Pain **Yes** **No**

Year Diagnosed _____ Physician _____

Congestive Heart Failure **Yes** **No**

Year Diagnosed _____ Physician _____

Valvular Heart Disease **Yes** **No**

(*Mitral Valve Prolapse, Mitral Valve Regurgitation, etc.)*

Year Diagnosed _____ Physician _____

Rheumatic Fever **Yes** **No**

Year Diagnosed _____ Physician _____

Heart Murmur **Yes** **No**

Year Diagnosed _____ Physician _____

Heart Arrhythmia (*Irregular Heart Beat)* **Yes** **No**

Year Diagnosed _____ Physician _____

High Blood Pressure/ Hypertension **Yes** **No**

Year Diagnosed _____ Physician _____

The above is true and correct to the best of my belief _____

Patient Signature

PULMONARY:

Asthma **Yes** **No**

Year Diagnosed _____ **Physician** _____

Pneumonia **Yes** **No**

Year Diagnosed _____ **Physician** _____

Bronchitis **Yes** **No**

Year Diagnosed _____ **Physician** _____

COPD (Emphysema) **Yes** **No**

Year Diagnosed _____ **Physician** _____

Tuberculosis **Yes** **No**

Year Diagnosed _____ **Physician** _____

Diagnosed Sleep Apnea **Yes** **No**

Year Diagnosed _____ **Physician** _____

If yes, please indicate what type of treatment _____

Obesity Hypoventilation Syndrome **Yes** **No**

Year Diagnosed _____ **Physician** _____

Pulmonary Hypertension **Yes** **No**

Year Diagnosed _____ **Physician** _____

ENDOCRINE:

Diabetes Mellitus **Yes** **No**

Year Diagnosed _____ **Physician** _____

If yes, do you currently treat with insulin? **Yes** **No**

Do you currently treat with oral medications? **Yes** **No**

Do you currently treat with both? **Yes** **No**

The above is true and correct to the best of my belief _____

Patient Signature

ENDOCRINE: (continued)

Hyperthyroid **Yes** **No**

Year Diagnosed _____ **Physician** _____

Hypothyroid **Yes** **No**

Year Diagnosed _____ **Physician** _____

Adrenal (Cushing's) **Yes** **No**

Year Diagnosed _____ **Physician** _____

GASTROINTESTINAL:

Reflux Disease (Heartburn) **Yes** **No**

Year Diagnosed _____ **Physician** _____

Peptic Ulcer Disease **Yes** **No**

Year Diagnosed _____ **Physician** _____

Gallbladder Disease **Yes** **No**

Year Diagnosed _____ **Physician** _____

Liver Disease **Yes** **No**

Year Diagnosed _____ **Physician** _____

Inflammatory Bowel Disease **Yes** **No**

Year Diagnosed _____ **Physician** _____

Hiatal Hernia **Yes** **No**

Year Diagnosed _____ **Physician** _____

Irritable Bowel Syndrome **Yes** **No**

Year Diagnosed _____ **Physician** _____

The above is true and correct to the best of my belief _____

Patient Signature

CANCER:

Type/Organ affected: _____ Treatment: _____

PERIPHERAL VASCULAR DISEASE:

Arterial Vascular Disease **Yes** **No**

Year Diagnosed _____ Physician _____

Pulmonary Embolism **Yes** **No**

Year Diagnosed _____ Physician _____

DVT (Phlebitis) **Yes** **No**

Year Diagnosed _____ Physician _____

Superficial Phlebitis **Yes** **No**

Year Diagnosed _____ Physician _____

Peripheral Edema (swelling of legs, ankles) **Yes** **No**

Year Diagnosed _____ Physician _____

If yes, do you treat with diuretics? **Yes** **No**

Leg Ulcers **Yes** **No**

Year Diagnosed _____ Physician _____

Varicose Veins **Yes** **No**

Year Diagnosed _____ Physician _____

RENAL:

Kidney Disease **Yes** **No**

Year Diagnosed _____ Physician _____

Urinary Stress Incontinence **Yes** **No**

Year Diagnosed _____ Physician _____

Kidney Stones **Yes** **No**

Year Diagnosed _____ Physician _____

The above is true and correct to the best of my belief _____

Patient Signature

CENTRAL NERVOUS SYSTEM

Stroke **Yes** **No**

Year Diagnosed _____ Physician _____

Seizure **Yes** **No**

Year Diagnosed _____ Physician _____

Cerebral Aneurysm **Yes** **No**

Year Diagnosed _____ Physician _____

Arteriovenous Malformation **Yes** **No**

Year Diagnosed _____ Physician _____

Pseudo tumor Cerebri **Yes** **No**

Year Diagnosed _____ Physician _____

Multiple Sclerosis **Yes** **No**

Year Diagnosed _____ Physician _____

MUSCULOSKELETAL:

Functional status

No Impairment **Able to walk 200ft with cane or crutch**

Require Wheelchair **Unable to walk 200ft with cane or crutch**

Lower Back Pain **Yes** **No**

Year Diagnosed _____ Physician _____

Diagnosed Osteoarthritis/DJD **Yes** **No**

Year Diagnosed _____ Physician _____

Osteoporosis **Yes** **No**

Year Diagnosed _____ Physician _____

Painful Joints **Yes** **No**

Year Diagnosed _____ Physician _____

Autoimmune Disease **Yes** **No**

(*Ex. Lupus, Rheumatoid Arthritis, connective Tissue, etc.)*

Explain Further: _____

Year Diagnosed _____ Physician _____

The above is true and correct to the best of my belief _____

Patient Signature

MUSCULOSKELETAL cont.

Gout **Yes** **No**

Year Diagnosed _____ **Physician** _____

Fibromyalgia **Yes** **No**

Year Diagnosed _____ **Physician** _____

Treatment with exercise **Non-narcotic medications** **Narcotics**

Abdominal Skin/Pannus **Yes** **No**

No Symptoms **Irritation** **Interferes with ambulation**

Recurrent cellulitis and ulceration

BLOOD DISORDERS

Anemia **Yes** **No**

Year Diagnosed _____ **Physician** _____

If yes, what type:
_____?

Do you have or have you had any abnormalities with bleeding or clotting **Yes** **No**

If yes, explain: _____

PSYCHIATRIC DISORDERS:

Depression **Yes** **No**

Year Diagnosed _____ **Physician** _____

Mild, no treatment **Moderate with treatment**

Severe with intensive treatment **severe requiring hospitalization**

Bipolar Depression **Yes** **No**

Year Diagnosed _____ **Physician** _____.

Anxiety **Yes** **No**

Year Diagnosed _____ **Physician** _____

Schizophrenia **Yes** **No**

Year Diagnosed _____ **Physician** _____

Year Diagnosed _____ **Physician** _____

The above is true and correct to the best of my belief _____

Patient Signature

PSYCHIATRIC DISORDERS: (continued)

Eating Disorder **Yes** **No**

Year Diagnosed _____ Physician _____

If yes, what type:_____

Are you currently receiving therapy or medications? Yes **No**

OBSTETRICAL/GYNECOLOGOICAL:

Do you have a history of breast cancer? **Yes** **No**

If applicable:

Please indicate the number of pregnancies to term: _____

Please indicate the number of deliveries: _____

Please indicate whether you are: **Pre-menopausal** **Post-menopausal**

Menstrual Irregularities **Yes** **No**

If yes, please indicate what type: _____

Polycystic Ovarian Syndrome **Yes** **No**

OTHER MEDICAL DISORDERS:

_____
_____
_____
_____

The above is true and correct to the best of my belief _____

Patient Signature

PATIENT'S PHYSICIAN INFORMATION:

Name of Primary Care Physician _____

Address _____

Phone (_____) _____-_____ Fax (_____) _____-_____

Please indicate any other physician you see:

Physician Name: _____ Specialty: _____

Address _____

Phone (_____) _____-_____ Fax (_____) _____-_____

Physician Name: _____ Specialty: _____

Address _____

Phone (_____) _____-_____ Fax (_____) _____-_____

Physician Name: _____ Specialty: _____

Address _____

Phone (_____) _____-_____ Fax (_____) _____-_____

SOCIAL HISTORY:

Occupation _____

Full Time Part Time Temporary Retired

Disability- please indicate cause: _____

What is your current marital status?

Married Single Separated Divorced Widowed Partnered

What category best describes your highest grade or level of education?

High School College Graduate School Vocational Other_____

What is your religious affiliation?

Atheist Catholic Jehovah Witness Jewish Other_____

Do you have any children? _____ If yes, how many? _____

What are their names and ages? _____

The above is true and correct to the best of my belief _____

Patient Signature

SMOKING/DRUG/ALCOHOL HISTORY: **Do you currently use tobacco? Yes No**

Have you ever used tobacco? Yes No

If you answered yes to the above questions:

a. **What type of tobacco? Cigarettes Cigars Pipe Chew/Snuff**
b. **What age did you start tobacco use? _____**
c. **How many years have you used tobacco? _____**
d. **How much do/did you use per day? _____**
e. **If applicable, what age did you stop tobacco? _____**

Do you currently drink alcohol? Yes No

If you answered yes to the above question:

a. **What type of alcohol are you drinking? Wine Beer Liquor Mixed Drinks Other_____**
b. **Please indicate how many drinks you currently consume:**
   Per month _____
   Per week _____
   Per day _____

Have you ever had a problem with alcohol in the past? Yes No

If you answered yes to the above question:

a. **Please indicate how long: _____ Treatment: _____**
b. **What type of alcohol do/did you drink? Wine Beer Liquor Mixed Drinks Other_____**
c. **Please indicate how many drinks you have/had each day: _____**
d. **Have you ever used any illicit drugs? Yes No**
   (Example: Marijuana, Cocaine, Heroin, Amphetamine, etc.)
   If you answered yes, please indicate how long ago?
   5 months or less 6 months-1 year 1 year or more

PREVIOUS DIAGNOSTIC PROCEDURES

Please check any of the following diagnostic procedures performed within the last year and indicate where they were performed.

EKG _____ Chest X-ray _____ Echocardiogram_____

Stress Test _____ Heart Cath _____ Upper Endoscopy_____

Abdominal US _____ Upper GI _____ Colonoscopy _____

CT Scan _____ Pulmonary Function _____ Sleep Study _____

Other _____

The above is true and correct to the best of my belief _____

Patient Signature

FAMILY HISTORY

In this section please complete this chart to the best of your knowledge.

Has anyone in your family ever had a blood clot in their legs or their lungs? Yes No

Has anyone in your family ever had a stroke? Yes No

FAMILY MEMBER	APPROXIMATE WEIGHT	PRESENT AGE	IF DECEASED, AGE OF DEATH	IF DECEASED, LIST THE CAUSE OF DEATH	LIST MEDICAL PROBLEMS
MOTHER					
FATHER					
MATERNAL GRANDMOTHER					
MATERNAL GRANDFATHER					
PATERNAL GRANDMOTHER					
PATERNAL GRANDFATHER					
BROTHER					
SISTER					
CHILDREN					

The above is true and correct to the best of my belief _____

Patient Signature

Please list any specific questions or concerns that you may have, to ensure that Dr. Chebli can address them at your consultation.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

The above is true and correct to the best of my belief _____

Patient Signature

BARIATRIC PATIENT WEBSITE ACKNOWLEDGEMENT

I _____, acknowledge that I have reviewed Dr. Chebli's website, www.venicembs.com. I have read detailed explanations on:

1. Morbid Obesity
2. Surgical Options for Treatment
3. Benefits and Risks of Obesity Surgery
4. Expected Weight Loss
5. Surgical Techniques and Video

_____ _____

Patient Signature *Date*

FINANCIAL POLICY FOR SURGERY

It is important for you to understand your financial obligations associated with your surgery. Please review the following and sign to indicate your understanding and acceptance of this responsibility.

1. Payment of insurance co-payment prior to routine scheduled office visits is expected. This is required by your insurance company contract. If co-payment cannot be made at the time of services, your appointment will be rescheduled to the next available time.
2. We will bill your insurance company for services rendered. Once insurance payment has been made and credited to your account, you will then receive a statement for any outstanding portion of the account (deductible). We appreciate payment in full within 10 days. If payment cannot be made in full within 30 days of the first statement the we would appreciate you making arrangements with our billing office to set up a payment plan. A payment plan may be established with the office through the use of:
    a. Payment with a credit card
    b. Extension of a line of credit through a medical services credit company
    c. Establishing a monthly payment contract with our office
3. Statements will be made monthly for outstanding balances. If the account is not paid in full or no payment has been received by the fourth statement then the account balance may be forwarded to collections in accordance with the laws established by the state of Florida.
4. Prior to elective surgery we will confirm benefits and balances on deductibles with your insurance company. For your convenience, this will allow us to determine your portion of the bill prior to the procedure. Payment of this balance is required prior to the procedure.
5. Questions or concerns regarding your bills should be addressed directly with the billing staff and not your physician.

I am signing this document of my own free will, and understand my responsibilities for payment of the surgery, related care, and costs associated with any additional care needed after the surgery.

_____ _____

Patient or Authorized Representative Signature *Date*

Venice Metabolic and Bariatric Surgery
Chat Room Policy and Disclaimer

CHAT ROOM POLICY

While in a chat room the information you display can be viewed by others and is not private. The chat room is a public forum and you should not place any information there you do not wish other third parties to access or see. We will accept no liability for any personal or private information that you place in the chat room for the view of the public in general.

Terms of Use

1. I understand that the chat rooms are an open forum to share information and opinions about obesity concerns including bariatric surgery and weight loss are not a substitute for medical care.
2. I have read and understand the Disclaimer (link below)
3. I understand that weight loss surgery issues and weight loss care should always be discussed with a health care professional who is familiar with me and my situation.
4. Posting commercial message or messages prompting a product is prohibited and will results in the source computer being banned from using the chat rooms.
5. Soliciting for participants for focus groups, medical research or school research projects expressly prohibited.
6. Posting messages that harass, abuse, belittle, or threaten anyone is prohibited and will result in the source computer being banned from using the chat rooms.
7. Chat rooms are not moderated. Parents should supervise their children.
8. All chat rooms block certain inappropriate language but cannot block all words and phrases that might be deemed unacceptable to everyone.
9. Chat rooms are occasionally monitored by volunteers.
10. People who violate the terms of service can be banned by chat room monitors at their sole discretion.
11. The chat room terms of service can be updated at any time.

Disclaimer

1. Obesity is a serious disease that requires attentive care.
2. The information in this web site is for general information only, and should not be constructed as medical advice or diagnosis, nor as advice as to treatment of any specific medical condition.
3. The information, opinions, and recommendations presented in these pages are not intended to replace the care of your own healthcare providers.
4. Before you make any changes in the management of your obesity or weight loss, you should consult your healthcare provider of other qualified medical professionals.

Venice Metabolic and Bariatric Surgery

INTERNET CHAT POLICY and AGREEMENT

Many of our patient's like to go on-line to communicate with other bariatric patients as well as to seek information. While we encourage staying in communication with other patients who are experiencing the same issues you may be, it is important that you understand that while on-line at any Internet chat room, site or similar forum that the information you provide can be viewed by others and is not private. These forums are public and may not be regulated. Further, you will not be able to control the information as to third parties – their access or use of your private information. In addition, information obtained in the chat room may not be medically sound and even though it may have worked for someone else, the suggestion may not work for you at all, or even worse, be harmful to you.

Venice Metabolic and Bariatric Surgery wants you to understand that we will accept no liability for any personal or private information you place in a chat room for the view of the public in general, not for any medical advice you obtain in this manner. Venice Metabolic and Bariatric Surgery also needs to protect itself from those people who, for reasons of their own, may make libelous, slanderous, and/or inaccurate statements about our practice, or who may give advice or share information that they claim to have received from our practice, when in fact they did not receive it from our practice at all or they misunderstood or misinterpreted what they were told. Venice Metabolic and Bariatric, under such circumstances, will pursue any and all available legal remedies.

Having read the above, and by signing this policy and agreement, I acknowledge that I understand the content of this policy and agree to the following:

1. Internet chat site are open forums to share information and opinions about obesity concerns including bariatric surgery and weight loss and are never a substitute for medical care.
2. Weight loss surgery issues and weight loss care should always be discussed with a health care professional who is familiar with me and my situation.
3. Posting messages that harass, abuse, belittle or threaten anyone, including Venice Metabolic and Bariatric Surgery in general may result in my discharge from the practice.

Patient Name: _____

Patient Signature: _____ Date: _____

SOUTHWEST FLORIDA METABOLIC AND BARIATRIC SURGERY AUTHORIZATION FOR RELEASE OF INFORMATION

_____ _____

Patient Name **D.O.B.**

Please send information to: Joseph E. Chebli, MD, FACS
1370 E. Venice Ave. Suite 208
Venice, FL 34285
Phone: (941)209-4646
Fax: (941)445-4152

Information to be released:

☐ Most recent 2 years of pertinent information (chart notes, labs, x-rays, and tests)
☐ All medical records
☐ Specific information (Please specify)

_____
_____
_____

Purpose for which disclosure is being made: Continuity of Care

Patient Authorization: I understand that my records may contain information regarding the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give specific authorization for these records to be released.

_____ Exclude the following information from the records to be released (please initial)
_____ Drug/Alcohol abuse/treatment & diagnosis _____ Sexually Transmitted Disease
_____ HIV/AIDS diagnosis/treatment/testing _____ Mental Illness/ Psychiatric Treatment

My Rights:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment). I may revoke this authorization in writing. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under privacy laws.

Signature _____ Date _____

This authorization will expire 1 year from the date signed