# 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: HISTORY BILLING |
|---|---|---|
| NAME | RELATIONSHIP | CAN DISCUSS MY: HISTORY BILLING |
| NAME | RELATIONSHIP | CAN DISCUSS MY: HISTORY BILLING |

## 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**

# NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

**When the Notice refers to "we" or "us," it is referring to, Joseph E. Chebli, MD, FACS all of the Physicians in the Practice, and all of our employees.**

**This Notice describes how we will use and disclose your protected health information. The policies outlined in this Notice apply to all of your health information generated by us, whether recorded in your medical record, invoices, payment forms, videotapes or other ways. Similarly, these policies apply to the protected health information gathered from other organizations by any health care professional, employee or volunteer who participates in your care.**

## USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

1. In some circumstances we are permitted or required to use or disclose your protected health information without obtaining your prior authorization and without offering you the opportunity to object. These circumstances include;
    a. Uses or disclosures for purposes relating to treatment, payment and health care operations:

    1. **TREATMENT**. We may use or disclose your protected health information for the purpose of providing, or allowing others to provide, treatment to you or any other individual. An example would be if your physician discloses your health information to another doctor for the purposes of a consultation. Also, we may contact you with appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

**II. PAYMENT. We may use and/or disclose your protected health information for the purpose of allowing us, as well as other entities, to secure payment for the health care services provided to you. For example, we may inform your health insurance company of your diagnosis and treatment in order to assist the inquirer in processing our claim for payment for health care services provided to you.**

**III. HEALTH CARE OPERATIONS. We may use and/or disclose your information for the purposes of our day-to-day operations and functions. We may also disclose your information to another covered entity to allow it to perform its day-to-day functions to the extent that we both have a relationship with you or if we are part of an "organized health care management" with the other entity, such as the hospitals where**

**our physicians practice. For example, we may compile your protected health information, along with that of other patients, in order to allow us to review that information and make suggestions concerning how to improve the quality of care.**

b. To create materials(s) that originally had any identifying information concerning you deleted from the final material(s);
c. To create materials that have most of the identifying information about you deleted from the final materials, to allow other entities to conduct research, public health, or health care operation activities;
d. When required by law;
e. For public health purposes;
f. To disclose information about victims of abuse, neglect, or domestic violence;
g. For health oversight activities, such as audits or civil, administrative or criminal investigations;
h. For judicial or administrative proceedings;
i. For law enforcement purposes;
j. To assist coroners, medical examiners or funeral directors with their official duties;
k. To facilitate organ, eye or tissue donation;
l. For certain research projects that have been evaluated and approved through a research approval process that takes into account patients' need for privacy;
m. To avert a serious threat to health or safety;
n. For specialized governmental functions, such as military, national security, criminal corrections, or public benefit purposes; and
o. For workers' compensation purposes, as permitted by law.

2. We may also disclose to your relatives or close personal friends any protected health information that is directly related to that person's involvement in the provision of, or payment for your care. We may also use and disclose your protected health information for the purpose of loading and notifying your relatives or close personal friends of your location and general condition or death, and to Organizations that are involved in those tasks during disaster situations. Except in emergency situations, we will inform you that we intend to share information in this way and will give you an opportunity to object.

**Except as described above, disclosures of your protected health information will be made only with your written authorization. You may revoke your authorization at any time, in writing, unless we have taken action in reliance upon your prior authorization, or if you signed the authorization as a condition or obtaining insurance coverage.**

## YOUR RIGHTS

1. **TO REQUEST RESTRICTIONS**. You have the right to request restrictions on the use and disclosure of your protected health information for treatment, payment or health care operations purposes or notification purposes. We are not required to agree to your request. If we do agree to a restriction, we will abide by that restriction unless you are in need of emergency treatment and the restricted information is needed to provide that emergency treatment. To request a restriction, submit a written request to the Contact Person listed on the final page of this Notice.

2. **TO LIMIT COMMUNICATIONS**. You have the right to receive confidential communications about your own protected health information by alternative means or at alternative locations. This means that you may, for example designate that we contact you only via e-mail, or at work rather than home. To request communications via alternative means or at alternative locations, you must submit a written request to the Contact Person listed on the final page of this Notice. All reasonable requests will be granted.

3. **TO ACCESS AND COPY HEALTH INFORMATION**. You have the right to inspect and copy any protected health information about you, that we use to make decisions about you, other than psychotherapy notes, information compiled in anticipation of or for use in civil, criminal or administrative proceedings, or certain information that is governed by the Clinical Laboratory Improvement Act. To arrange for access to your records, or to receive a copy of your records, you should submit a written request to the Contact Person listed on the last page of this Notice. If you request copies, you will be charged our regular fee for copying and mailing the requested information.

**Despite your general right to access your Protected Health Information, access may be denied in some limited circumstances. For example, access may be denied if you are an inmate at a correctional institution or if you are a participant in a research program that is still in progress. Access may be denied if the federal Privacy Act applies. Access to information that was obtained from someone other than a health care provider under a promise of confidentiality can be denied if allowing you access would reasonably be likely to reveal the source of the information. The decision to deny access under these circumstances is final and not subject to review.**

**In addition, access may be denied if, (I) access to the information in question is reasonably likely to endanger the life and physical safety of you or anyone else, (II) the information makes reference to another person and your access would reasonably be likely to cause harm to that person, or (III) you are the personal representative of another individual and a licensed health care professional determines that your access to the information would cause substantial harm to the patient or another individual. If access is denied for these reasons, you have the right to have the decision reviewed by a health**

**care professional who did not participate in the original decision. If access is ultimately denied, the reasons for that denial will be provided to you in writing.**

4. **TO REQUEST AMENDMENT**. You may request that your protected health information be amended. Your request may be denied if the information in question; was not created by us (unless you show that the original source of the information is no longer available to seek amendment from), is not part of our records, is not the type of information that would be available to you for inspection or copying (for example, psychotherapy notes), or is accurate and complete. If your request to amend your protected health information is denied, you may submit a written statement disagreeing with the denial, which we will keep on file and distribute with all future disclosures of the information to which it relates. Requests to amend protected health information must be submitted in writing to the Contact Person listed on the final page of this Notice.

5. **TO AN ACCOUNTING OF DISCLOSURES**. You have the right to an accounting of any disclosures of your protected health information made during the six-year period preceding the date of your request. However, the following disclosures will not be accounted for. (I) disclosures made for the purpose of carrying out treatment, payment or health care operations, (II) disclosures made to you, (III) disclosures of information maintained in our patient directory, or disclosures made to persons involved in your care, or for the purpose of notifying your family or friends about your whereabouts, (IV) disclosures for national security or intelligence purposes, (V) disclosures to correctional institutions or law enforcement officials who had you in custody at the time of disclosure, (VI) disclosures that occurred prior to April 14, 2003, (VII) disclosures made pursuant to an authorization signed by you, (VIII) disclosures that are a part of a limited date set, (IX) disclosures that are incidental to another permissible use or disclosure, or (X) disclosures made to a health oversight agency or law enforcement official, but only if the agency or official asks us not to account to you for such disclosures and only for the limited period of time covered by that request. The accounting will include the date of each disclosure, the name of the entity or person who received the information and that person's address (if known), and a brief description of the information disclosed and the purpose of the disclosure. To request an accounting of disclosure, submit a written request to the Contact Person listed on the final page of this Notice.

6. **TO A PAPER COPY OF THIS NOTICE**. You have the right to obtain a paper copy of this Notice upon request.

## OUR DUTIES

1. We are required by law to maintain the privacy of your protected health information and to provide you with this Notice of our legal duties and privacy practices.

2. We are required to abide by the terms of this Notice. We reserve the right to change the terms of this Notice and to make those changes applicable to all protected health information that we maintain. Any changes to the Notice will be posted at our office, and will be available from us upon request.

## COMPLAINTS

**You can complain to us and to the Secretary of the federal Department of Health and Human Services if you believe your privacy rights have been violated. To lodge a complaint with us, please file a written complaint with the Contact Person set forth below. This contact person will also provide you with further information about our privacy policies upon request. No action will be taken against you for filing a complaint.**

## Designated Contact Person: Joseph E. Chebli, MD, FACS 1700 E. Venice Ave

**Venice, FL 34292**

**941-483-9731**

## SUMMARY NOTICE OF PRIVACY PRACTICES

**We are required by federal law to provide a Notice of Privacy Practices that describes how health information that we maintain about you may be used or disclosed. The Notice describes each use and disclosure that we are permitted to make, and provides a description of your rights and our obligations under federal and state privacy laws.**

## CONSENT FOR EVALUATION AND TREATMENT

**I hereby authorize Joseph E. Chebli, MD and/or his affiliates, their physicians, employees or agent, together with any laboratory designated by Joseph E. Chebli, MD or any of his affiliates to perform a physical examination and/or any medical treatment deemed necessary by the treating physicians. This includes, but is not limited to, any required medical examinations, x-rays, medical procedures and medical, diagnostic or laboratory test ordered by the physician(s) to be carried out by the designated staff.**

**I voluntarily authorize Joseph E. Chebli, MD and/or his affiliates, their physician, employees or agents, together with any laboratory to obtain a specimen of my urine, blood, and/or breath for the purpose of determining the presence of drugs and/or alcohol, if applicable.**

## RELEASE OF INFORMATION

**I voluntarily authorize Joseph E. Chebli, MD and/or his affiliates to disclose to my employer, prospective employer, insurance company and/or any third party payer all medical information, test results and findings made during the course of this examination and/or treatment. I authorize Joseph E. Chebli, MD to release any appropriate information concerning my medical history, examinations, treatments, or other diagnostic procedures, including copies of my records to official requesters, including but not limited to insurance companies, third party administrators, or utilization, review organizations, health care service plans, or to any other person or entity as necessary in connection with certification, payment or reimbursement for services rendered. I acknowledge that such information may be released pursuant to the following paragraph.**

## CONFIDENTIALITY

**It is the policy of Joseph E. Chebli, MD and his affiliates to protect all medical records against loss, tampering, destruction and access by unauthorized persons. I understand that medical records maybe periodically reviewed by national accreditation or certification surveyors, and other necessary quality assurance personnel and I authorize such release of information. I acknowledge that my records and associated documentation may be disclosed to third-parties, including government agencies, as required by law, including, but not limited to, pursuant to warrant, subpoena or court order, and I hereby agree not to pursue any action against Joseph E., Chebli, MD and/or his affiliates for any damage I may suffer as a result of such disclosure.**

## ASSIGNMENT OF BENEFITS

**I hereby authorize and assign to Joseph E. Chebli, MD and/or his affiliates any and all benefit of payments for services rendered under terms of my insurance policies, and hereby individually obligate the payer to pay the account to Joseph E. Chebli, MD and/or his affiliates in accordance with the standard and customary charges incurred during my period of treatment.**

## FINANCIAL AGREEMENT

**I understand I am responsible for all deductibles, co-pays and charges for services rendered to me but not covered by my insurer. If I am liable for payment, a list of charges will be made available to me within (30 days) from the date Joseph E. Chebli, MD and/or his affiliates become aware of my insurance ineligibility. Should the account be referred to collection, the undersigned shall pay the collection expenses incurred by Joseph E. Chebli, MD and/or his affiliates, including, without limitation, court costs and attorney's fees.**

## USES AND DISCLOSURES

**We are permitted to use and disclose your health information under a variety of circumstances. Sometimes we must obtain your authorization before we use or disclose that information, but in other circumstances we may use your information without your authorization and without informing you of the use or disclosure. Some of the reasons that we may use or disclose your information include:**

**. to provide information about your health condition to others who may treat you;**
**. to provide information about the treatment that we provided in order to obtain payment from your health plan;**
**. to report a communicable disease, domestic violence or criminal activity; or**
**. to comply with a court order requiring the disclosure of your medical record.**
**These are just a few examples. For a full description of the uses and disclosures that we are permitted to make, consult the Notice of Privacy Practices.**

## YOUR RIGHTS

**While the records that we maintain about you belong to us, under the federal privacy law you have a variety of rights with respect to the information maintained in those records. For instance, you have the right to access and copy the health information that we maintain about you and to request that we amend any of the information that you believe is incomplete or incorrect. Also, you may request that we provide you with a list of each disclosure that we have made of your health information. All of these rights are subject to some exceptions that are described fully in the Notice.**

## OUR OBLIGATION

**We are required to provide you with our Notice of Privacy Practices and to abide by its terms. We may amend the Notice from time to time. All amendments apply retroactively.**

**Our full Notice of Privacy Practices is attached or enclosed. Please read it carefully. If you have any questions or require additional information please contact:**

**Joseph E. Chebli, MD, FACS Privacy Officer**
**941-483-9731**

**By my signature below I acknowledge that I have fully read Dr. Joseph E. Chebli's Summary Notice of Privacy Practices and fully understand it's contents and have been given a copy of the Notice of Privacy Practices.**

_____

**Patient or legally authorized individual signature** **Date**

_____

**Printed name if signed on behalf of patient** **Relationship**