NPB

Selim Metabolic and Bariatric Center
215 W. Prien Lake Rd.
Lake Charles, LA 70601

Phone: (337) 502-8706 **Fax:** (337) 210-1271

PATIENT DEMOGRAPHIC SHEET

Today's Date: _____

Patient Name_____ Birth Date_____ Sex: M F
SSN_____-_____-_____ Marital Status: M S D W O Race: _____
Address _____ City_____ State_____ Zip_____
Phone: Home: (____)_____-_____ Cell: (____)_____-_____ Work: (____)_____-_____
What is your preferred method of contact: phone ____ text message ____ email____
Is it okay to leave a message regarding medications, labs, appointments, or instructions? Yes No
Is it okay to text a message for reminder of appointments? Yes No

Email address: (for communication from our office, notice of upcoming events, and our office appointments) _____

INSURANCE INFORMATION

Primary Insurance_____
Subscriber name: (if not patient)_____
Relationship_____ DOB_____ SSN_____-_____-_____
Insurance ID/Policy ID: _____ Group # _____
Employer Of Insured:
Secondary Insurance (YES NO)_____Subscriber (if different)_____
Relationship_____ DOB_____ SSN_____-_____-_____
Insurance ID/Policy ID: _____ Group # _____
Employer of Insured: _____

EMERGENCY CONTACT

Name: Relation to contact:
Phone: Home: (____)_____-_____ Cell: (____)_____-_____ Work: (____)_____-_____
Full Address: _____

PHYSICIAN INFORMATION

Primary care physician: _____ Referring physician: _____

How did you hear about our office? _____

Chief Complain today: _____

Selim Metabolic and Bariatric Surgery Center
GASTROINTESTINAL, MINIMALLY INVASIVE, ROBOTIC AND BARIATRIC SURGERY

NIAZY SELIM, MD, PHD, FACS
215 W. Prien Lake Rd.
LAKE CHARLES, LA. 70601

TEL: (337) 502-8706
FAX: (337) 210-1271
WWW.SELIMSURGERYCENTER.COM

MEDICATION: Current Medications: (List all, including oral contraceptives, over the counter, herbal, or health supplements)

Drug	Dose	How often each day	Why do you take this medication
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

➡ Have you been prescribed narcotic pain medications in the past 1-year (if not listed above)? ☐ Yes ☐ No

If so, describe: _____

ALLERGIES AND RESTRICTION:

Drug (medication allergies:

Drug Name / Reaction

_____

_____

_____

_____

☐ **I have no drug allergies**

Contact Allergies:

☐ Latex ☐ adhesive
☐ tape
☐ Other
☐ I have no contact allergies.

Food Allergies:

☐ Yes ☐ No

_____ **(name of food)**

_____

☐ **I have no food allergies**

Dietary Restrictions:

☐ Vegetarian
☐ Vegan
☐ Kosher
☐ No Porc
☐ Lactose Intolerant
☐ Gluten
☐ Other:

☐ **I have no dietary restrictions**

PAST MEDICAL HISTORY:

1. _____
2. _____
3. _____
4. _____

SURGICAL HISTORY: **DIAGNOSTIC PROCEDURES:**

☐ **I have never had any surgery**			**Test**	**Date**	**Location**	**Reason**
Abdominal Surgeries:	**Year**		Last set of Blood work			
Gallbladder removal: ☐ Laparoscopic ☐ Open			Upper GI			
C-section:			Upper Endoscopy			
Appendix removal: ☐ Laparoscopic ☐ Open			Lower GI			
Hysterectomy: ☐ Transvaginal ☐ Abdominal ☐ Total ☐ Partial			Colonoscopy			
Tubal Ligation: ☐ Laparoscopic ☐ Open			Abdominal Ultrasound			
Hernia Repair: Mesh Placed ☐ Yes ☐ No			EKG or Stress test			
Bowel Resection: ☐ Laparoscopy ☐ Open ☐ Small Intestin ☐ Colon			Echo-Cardiogram			
Anti-reflux procedure:			Heart cath			
Nissen Fundoplication:			Sleep Study			
Vagatomy:			Pulmonary Function test			
Plastic Surgery: (Abdominal) ☐ Yes ☐ No			Chest x-ray			
Non-abdominal Operations:	**Year**		CT scan			
Peripheral vascular procedure:			MRI			
Knee replacement:			Manometry			
Hip replacement:						
Other hospitalization without surgery: _____ _____ _____ _____			**Surgical or Anesthesia problems:** ☐ Nausea and/or Vomiting ☐ Malignant Hyperthermia ☐ Bleeding tendency ☐ Difficult incubation ☐ **Complication after surgery:** _____			

FAMILY HISTORY:

Members	**Status**	**Diabetes**	**Hypertension**	**Heart Disease**	**Stroke**	**Mental Illness**	**Cancer**	**Unknown**
Father	Alive ☐ Deceased ☐							
Mother	Alive ☐ Deceased ☐							
Siblings	Alive ☐ Deceased ☐							
Children	Alive ☐ Deceased ☐							
Grandfather	Alive ☐ Deceased ☐							
Grandmother	Alive ☐ Deceased ☐							

FAMILY HISTORY CONT'D:

Siblings (how many?): _____ Brothers: _____ Sisters:_____ Healthy: ☐Yes ☐No
Children (how many?): _____ Sons: _____ Daughters:_____ Healthy: ☐Yes ☐No

Please explain any other information about your family which you want us to know:

_____
_____
_____
_____

SOCIAL HISTORY:

Race: ☐Black or African American ☐White ☐Decline to Specify
Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Decline to Specify
Language: ☐English ☐Spanish ☐Arabic ☐French ☐Chinese ☐Vietnamese ☐Korean ☐Japanese ☐Other: _____

Disability: Are you disabled? ☐ No ☐ Yes Type of Disability→_____

Have you used any of the following substances?	Substance	Currently Use?	Previously Used?	How many/much a day?
	Caffeine :coffee, tea, soda	☐Yes ☐No	☐Yes ☐No	
	Tobacco	☐Yes ☐No	☐Yes ☐No	
	Alcohol: beer, wine, liquor	☐Yes ☐No	☐Yes ☐No	
	Recreational/Street Drugs	☐Yes ☐No	☐Yes ☐No	

Have you ever had a blood transfusion? : ☐Yes ☐No

Have you had any travel in the past 6 months? ☐Yes ☐No If yes Where? _____ _____

REVIEW OF SYSTEMS:

➡ Do you have or have had any of the following problems on a **Persistent or Recurring** basis:

General:	☐difficulty with sleep	☐trouble sleeping	☐fever
	☐loss of sleep	☐poor appetite	☐weakness
	☐tire easily	☐weight change	☐bleeding problems
	☐sleepy during the day	☐loss of appetite	☐fatigue
	☐unexplained weight loss	☐unexplained weight gain	☐**None of the above**

Skin:	☐itching	☐bruising	☐dry sensitive skin
	☐tattoos	☐rash	☐hives
	☐body piercings	☐moles	☐keloid formation
	☐sores	☐lumps	☐acne
	☐dryness	☐hx of flexural eczema	☐skin cancer
	☐cellulitis (infection)	☐**No skin problems**	

Neuro:	☐lightheadedness	☐paralysis	☐seizures
	☐blackouts	☐confusion	☐insomnia
	☐fainting	☐headache	☐memory loss
	☐tremors	☐numbness/tingling	☐dizziness
	☐gait abnormality	☐stroke/CVA	☐pseudotumor cerebri
	☐nerve problems	☐migraines	☐**None of the above**

Eyes:

- ☐ yellow eyes
- ☐ eye pain
- ☐ redness
- ☐ cataract
- ☐ loss of vision
- ☐ contact lenses/ glasses
- ☐ glaucoma
- ☐ diminished vision
- ☐ eye irritation
- ☐ vision change
- ☐ drainage from eyes
- ☐ blurring of vision
- ☐ seasonal eye sx
- ☐ dander related eye sx
- ☐ **None of the above**

ENT:

- ☐ shortness of breath
- ☐ earaches
- ☐ history of emphysema
- ☐ hearing problems
- ☐ infection
- ☐ hay fever
- ☐ frequent nosebleeds
- ☐ hoarseness
- ☐ cold
- ☐ frequent sore throats
- ☐ sore tongue
- ☐ sore mouth
- ☐ excessive tooth decay
- ☐ chronic cough
- ☐ wheezing
- ☐ Asthma
- ☐ sinus trouble
- ☐ **None of the above**
- ☐ cough
- ☐ epistaxis (nosebleed)
- ☐ hearing loss
- ☐ change in voice
- ☐ sore throat
- ☐ ringing in ears
- ☐ sinus pain
- ☐ bad breath

Neck: ☐ goiter ☐ pain/stiffness ☐ lumps ☐ swollen glands

Cardiology:

- ☐ hypertension
- ☐ rheumatic fever
- ☐ palpitations
- ☐ irregular heart beat (a-fib)
- ☐ congestive heart failure
- ☐ high cholesterol
- ☐ cardiac catheterization
- ☐ diseased neck arteries (carotids)
- ☐ chest pain
- ☐ murmur
- ☐ edema
- ☐ heart disease
- ☐ heart valve problems
- ☐ high triglycerides
- ☐ heart bypass
- ☐ **No heart or blood vessel problems**
- ☐ cyanosis
- ☐ shortness of breath
- ☐ varicose veins
- ☐ cardiomyopathy
- ☐ heart attack (MI)
- ☐ diseased leg arteries (PVD)
- ☐ syncope (passing out)

Respiratory:

- ☐ asthma
- ☐ pulmonary embolus (clot in lungs)
- ☐ productive cough
- ☐ nighttime snoring (any)
- ☐ shortness of breath at rest
- ☐ home oxygen use
- ☐ pulmonary hypertension
- ☐ coughing up blood
- ☐ loud snoring
- ☐ **None of the above**
- ☐ obstructive sleep apnea
- ☐ COPD (emphysema or chronic bronchitis)
- ☐ pain with deep breath
- ☐ shortness of breath with activity

Hematology:

- ☐ history of blood transfusion
- ☐ transfusion reactions
- ☐ anemia
- ☐ clotting problems
- ☐ family history of blood clots
- ☐ **No hem/onc problems**
- ☐ easy bleeding
- ☐ easy bruising
- ☐ swollen glands
- ☐ HIV or AIDS
- ☐ cancer history
- ☐ fatigue
- ☐ loss of appetite
- ☐ varicose veins
- ☐ personal history of blood cots
- ☐ enlarged lymph nodes

GI:

- ☐ indigestion
- ☐ excessive thirst
- ☐ milk intolerance
- ☐ abdominal swelling
- ☐ vomiting blood
- ☐ hard stools
- ☐ use finger to evacuate stool
- ☐ straining
- ☐ excessive flatus (gas bloating)
- ☐ rectal pain
- ☐ Trouble controlling bowel movements/accidents
- ☐ nausea
- ☐ heartburn
- ☐ vomiting
- ☐ difficulty swallowing
- ☐ abdominal pain
- ☐ diarrhea
- ☐ constipation
- ☐ change in bowel habits
- ☐ blood in stool

Other GI:
- ☐ Gallstones
- ☐ history of pancreatitis
- ☐ inflamed or diseased gallbladder
- ☐ fatty liver (NASH)
- ☐ hepatitis (type: _____)
- ☐ GERD
- ☐ bile reflux
- ☐ Barrett's esophagus
- ☐ Schatzki's ring
- ☐ stomach or intestinal ulcer
- ☐ Crohn's disease
- ☐ Ulcerative Colitis
- ☐ colon cancer
- ☐ fecal incontinence (leaking)
- ☐ irritable bowel disorder
- ☐ diverticulitis
- ☐ hemorrhoids
- ☐ reflux /regurgitation
- ☐ jaundice (yellow tint to eyes or skin)
- ☐ hernia (☐ Hiatal ☐ incisional ☐ umbilical ☐ inguinal)
- ☐ **None of the above**

Endocrine:
- ☐ polyuria
- ☐ cold intolerance
- ☐ excessive sweating
- ☐ weight loss
- ☐ heat intolerance
- ☐ polydipsia
- ☐ sleep disturbance
- ☐ diabetes (type 1 or type 2)
- ☐ diabetes nerve problems
- ☐ diabetes eye problems
- ☐ diabetes ulcers
- ☐ glucose intolerance/pre-diabetes
- ☐ low thyroid level (hypothyroid)
- ☐ high thyroid level (hyperthyroid)
- ☐ infertility
- ☐ hypoglycemia (low blood sugar)
- ☐ metabolic syndrome
- ☐ morbid obesity
- ☐ excessive thirst
- ☐ excessive hunger
- ☐ excessive urination
- ☐ Polycystic Ovary Syndrome (PCOS)
- ☐ **No endocrine problems**

Extremities:
- ☐ muscle pain
- ☐ varicose veins
- ☐ leg cramps
- ☐ gout
- ☐ joint pain
- ☐ cold sensitivity
- ☐ ulcers on legs and feet
- ☐ backache
- ☐ redness and swelling of joints.
- ☐ **None of the above**

Musculo-Skeletal:
- ☐ back pain
- ☐ joint pain
- ☐ sciatica
- ☐ gout
- ☐ joint swelling
- ☐ fracture
- ☐ joint stiffness
- ☐ leg cramps
- ☐ carpal tunnel
- ☐ osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ degenerative joint disease
- ☐ degenerative disk disease
- ☐ herniated disk
- ☐ fibromyalgia
- ☐ lymphedema
- ☐ neck pain
- ☐ hip pain
- ☐ knee pain
- ☐ ankle or foot pain
- ☐ back pain
- ☐ wrist pain
- ☐ shoulder pain
- ☐ muscle weakness
- ☐ **None of the above**

Psych:
- ☐ nervousness
- ☐ tension/stress
- ☐ eating disorders
- ☐ manic symptoms
- ☐ sleep disturbance
- ☐ mental or physical abuse
- ☐ bad mood
- ☐ suicidal thoughts
- ☐ anxiety
- ☐ depression
- ☐ ADHD
- ☐ bipolar disorder
- ☐ schizophrenia
- ☐ prior psychiatric hospitalization
- ☐ eating disorder
- ☐ panic attacks
- ☐ hallucinations
- ☐ memory loss/confusion

Genito Urinary Female:
- ☐ excessive urination
- ☐ past sexually transmitted disease
- ☐ urgency
- ☐ burning
- ☐ loss of interest in sex
- ☐ heavy periods
- ☐ kidney stones
- ☐ excessive blood loss
- ☐ difficulty urinating
- ☐ sores
- ☐ menopause
- ☐ increased urinary frequency
- ☐ lumps
- ☐ difficulty holding urine/accidents
- ☐ pelvic pain
- ☐ Pain during intercourse
- ☐ last menstrual period
- ☐ dysmenorrhea
- ☐ hernia
- ☐ blood in urine
- ☐ vaginal discharge
- ☐ hot flashes
- ☐ kidney failure
- ☐ **No kidneys and GU problems**

Genito	☐ blood in urine	☐ impotence	☐ hernia
Urinary	☐ excessive urination	☐ loss of interest in sex	☐ undescended testicle
Male:	☐ burning	☐ difficulty holding urine/accidents	☐ kidney disease
	☐ sores	☐ kidney stones	☐ hard testicle
	☐ lumps	☐ difficulty urinating	☐ hypospadias
	☐ vaginal discharge	☐ increased urinary frequency	☐ retractile testicle
	☐ past sexually transmitted disease	☐ kidney failure	☐ urinary stress incontinence
	☐ **No kidneys and GU problems**		

Please provide details of medical history marked above or any other condition you have that is not listed above:

_____

_____

_____

_____

Last menstrual period: _____

Pap Smear date: _____ ☐ **Normal** ☐ **Abnormal**

Mammogram date: _____ ☐ **Normal** ☐ **Abnormal**

Pharmacy Contact Information:

Pharmacy Name: _____

Pharmacy Address:_____

Pharmacy Phone: _____

By signing below, you authorize Louisiana Surgeons of Excellence to obtain your list of medications.

_____ _____

Patient Signature *Date*

I authorize release of any information concerning me (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

_____ _____

Patient Signature or Parent if minor *Date*

Employment Status: ☐ Full Time ☐ Part Time ☐ Homemaker ☐ Student ☐ Retired ☐ Disabled ☐ Unemployed

Occupation:_____

Employer: _____

Please List all The Healthcare Providers who have treated you in the last 5 years:

Provider (MD,DO, NP, PA)	Address	Phone
PCP:		
Cardiologist:		
Pulmonologist:		
Neurologist:		
Mental Health:		
OB/GYN:		
Pain Management:		
Oncologist:		
Surgeon:		
Other		

History of Weight Gain

How long have you been overweight? _____ What is your: Lowest adult weight? _____ Highest adult weight? _____
List your average wt for the last 5 years: 2016:_____ 2015:_____ 2014:_____ 2013:_____ 2012: _____

What is your current weight? _____ pounds This is based on: ☐an estimate ☐home scale ☐Dr. office scale

What is your current height? Feet: ____ inches: ____ This is based on: ☐an estimate ☐an actual measurement

Weight Loss Medications

Please indicate which medications you have used to lose weight.	Dates or Number of months on medication: Any problems from taking the medication:	Pounds lost (est.)
Meridian (sibutramine)		
Alli or Xenical (orlistat)		
Adipex (phentermine)		
Redux (dexfenfluramine)		
Fen-phen		
Qsymia (phentermine/topiramate)		
Belviq (locaserin)		
Contrave (naltrexone/bupropion)		
Any over the counter:		
Other		

Weight Loss Attempt History

Please indicate which diets you have tried in the past:	Dates	Pounds lost
Calorie counting (on my own)		
Atkins diet / South Beach (or other low-carb diet)		
Weight Watchers		
Optifast / Medifast / Slimfast		
Jenny Craig / Nutrisystem		
Cabbage Soup / Grapefruit		
Other		
Other		
Most lost in any one attempt?		

Weight Loss Surgery History (fill this out ONLY if you have had surgery for weight loss in the past)

Have you previously had weight loss surgery? ☐Yes ☐No (if no skip this section)

What year? _____

Which operation? ☐Gastric Bypass (Roux-en-Y) ☐Duodenal Switch ☐Lap Band or RealizeBand (adjustable band)
☐Vertical Sleeve Gastrectomy ☐Vertical Banded Gastroplasty/ Horizontal Gastroplasty Other: _____

Name of Surgeon: _____ Last seen: _____ if applicable, last band adjustment: _____

Weight before bariatric surgery: _____ lbs

Lowest weight achieved after bariatric surgery: _____ lbs

Did you have and adverse events occur during or after the previous bariatric surgery?
☐Yes ☐No if "yes" please explain:

Dietary and Physical Activity Assessment

Why are you interested in weight loss surgery?

☐Lose weight ☐Treat medical problem
☐other _____
☐Interested in medical weight loss only

Dining out History: circle

How many times to you eat out each week?

☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-8 ☐ 9 or more

Which of the following factors do you feel contributes to your obesity?

☐Frequent snacking
☐Poor food choices
☐Large portions
☐Nighttime eating
☐Medications
Other _____

Physical Activity:
Do you exercise? ☐Yes ☐No

If yes, how many times a week? _____

What type (s) of exercise do you do?

_____

Dietary Recall: circle

How many meals do you eat each day?

1 2 3 4 5 or more
☐ ☐ ☐ ☐ ☐

How many times do you snack each day?

1 2 3 4 5 or more
☐ ☐ ☐ ☐ ☐

Which eal is the most challenging?

☐Breakfast☐Lunch☐Dinner

Nutrition: have you been told any of the following?
(mark any that apply)

Vitamin deficiencies:

Vit. A☐ Vit. B1(thiamine☐ Vit B12☐ Vit. D☐

Additional:

Protein deficient☐ iron deficient☐

Other _____

Psychosocial History

Any Alcohol Use:
☐Yes ☐No
If yes, describe frequency and amount?

Any History of Drug Abuse
☐Yes ☐No
If yes, describe frequency and amount?

Any <u>current</u> Tobacco Use
☐Yes ☐No

<u>If yes what form of tobacco?</u>

☐Cigs☐Cigars☐Dip☐Chew☐E-cigs
Other _____

<u>How often?</u>
☐>2 packs per day
☐1-2 packs per day
☐<1 pack per day
☐Dip or Chew or Other _____

<u>Any **past** use of tobacco/nicotine?</u>
☐Yes ☐No

Starting age? _____

What year did you quit? _____

Any Difficulty with Daily Tasks:

Can you:

Can take care of self, such as eat, dress, or use the toilet
Yes **No**

Can walk up a flight of steps or a hill or walk on level ground at 3 to 4 mph

Yes **No**

Can do heavy work around the house such as scrubbing floors or lifting or moving heavy furniture or climb two flights of stairs
Yes **No**

Can participate in strenuous sports such as swimming, singles tennis, football, basketball, and skiing
Yes **No**

Religious beliefs:

May you receive blood or blood products?
☐Yes ☐No

Any dietary restrictions?
☐Yes ☐No

If yes: _____
_____

Other: _____
_____
_____

Support System:
Who is your support system for your weight loss? _____

Sleep Questionnaires

To be completed by the patient:

Do you SNORE loudly (louder than talking or loud enough to be heard through closed doors)?
☐ **Yes** ☐ **No**

Do you often feel TIRED, fatigued, or sleepy during daytime?
☐ **Yes** ☐ **No**

Has anyone OBSERVED you stop breathing during your sleep?
☐ **Yes** ☐ **No**

Do you have or are you being treated for high blood pressure**?**
☐ **Yes** ☐ **No**

To be completed by the Office:

BMI more than 35kg/m2? ☐ **Yes** ☐ **No**
AGE over 50 years old? ☐ **Yes** ☐ **No**
NECK circumference > 16 inches (40cm)? ☐ **Yes** ☐ **No**
GENDER: Male? ☐ **Yes** ☐ **No**

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?
This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:
0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Chance of Dozing Answer 0-3

Situation	Chance of Dozing
1. Sitting, inactive in a public place (e.g., theater or a meeting	☐0 ☐1 ☐2 ☐3
2. Watching TV	☐0 ☐1 ☐2 ☐3
3. Sitting and Reading	☐0 ☐1 ☐2 ☐3
4. Sitting and talking to someone	☐0 ☐1 ☐2 ☐3
5. Sitting quietly after lunch without alcohol	☐0 ☐1 ☐2 ☐3
6. As a passenger in a car for an hour without a break	☐0 ☐1 ☐2 ☐3
7. Lying down to rest in the afternoon when circumstances permit	☐0 ☐1 ☐2 ☐3
8. In a car, while stopped for a few minutes in the traffic	☐0 ☐1 ☐2 ☐3

1 – 6: Congratulations, you are getting enough sleep!
7 – 8: Your score is average
9 - >: Seek the advice of a sleep specialist without delay

Final Thoughts:

Please provide any comments or questions here that you would like:

Insurance coverage and benefits verification

You are responsible to check on your policy before your first visit.

Many patients ask: ***"Will my insurance pay for Bariatric surgery?"***

This answer is an individual one that pertains to each individual insurance company and individual policy. Every company has an exclusion section that explains the treatments for which the company will or will not pay. **If your policy states that it excludes the surgical treatment of obesity; unfortunately, it will not pay for Bariatric surgery no matter what your personal health circumstance may be or even if your doctor states that it is "medically necessary."**

Although our office verifies the patient's benefits after your initial consult, it is still the responsibility of each patient to call their insurance companies to get a full explaination of their coverage and benefits prior to their first consult. This will also enable each patient to ask specific questions to the insurance company and have a better understanding of what your benefits, deductibles and out of pocket expenses will be.

How to Verify Your Insurance Benefits

- Call the number on the back of your insurance card listed beside customer service.
- Tell insurance company you want to verify coverage and benefits for Bariatric Surgery

Diagnosis Code E66.01 (Morbid Obesity)
Procedure Codes 43644 (Gastric Bypass In-patient)
43775 (Gastric Sleeve In-patient)

Information to ask for:

Specialists Co-Pay: _____
Facility Co-Pay: _____

Deductible: _____
Amount Met: _____
After Deductible is met, covered at: _____ %

Co-Insurance: _____

Out of Pocket Max: _____
Amount Met: _____
After OOP is met, covered at: _____ %

Is a weight history required? ☐ YES ☐ NO
If so, how many months / years are required: _____ ☐ MONTHS ☐ YEARS

Is a Bariatric Center of Excellence Facility Required? ☐ YES ☐ NO

Designation of Personal Representative

As required by the Health Insurance Portability and Accountability Act of 1996 you have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form you are informing us of your wish to designate the named person as your personal representative. You may revoke this designation at any time by signing and dating the revocation of your copy of this form and return it to the office.

I, _____ (**patient name**) herby nominate the following person to act as my personal representative with respect to decision involving the use and/or disclosure of health information that pertains me. You may list as many people as you like just list them below.

I hereby authorize medical providers and personnel of Selim Surgery Center to discuss my protected health information with(*This person is to be afforded all of the privileges that would be afforded to me with respect to my health)*:

(**Print Name of Personal Representative)** _____
(Relationship to Patient) _____
(Phone # of Personal Representative) _____

_____ _____
Signature *Date*

_____ _____
Witness *Date*

***Your patient information is *confidential*, by naming someone as your personal representative this gives us your permission to discuss your patient information with that person. (Example: Spouse, daughter, son, etc.) ***

Or

I understand that I may revoke this designation at any time by signing the revocation section of my copy of this form and returning it to 215 W. Prien Lake Rd., Lake Charles LA 70601-8450. I further understand that any such revocation does not apply to the extent that persons authorized to use of disclose my health information have already acted in reliance on this designation.

I hereby revoke this designation of a personal representative. _____ **I DO NOT** authorize Selim Surgery Center to release ANY medical or appointment information to anyone.
(this means we will only discuss your medical record with you)

_____ _____
Signature *Date*

_____ _____
Witness *Date*

APPOINTMENT POLICIES

Welcome to our practice. We are proud to serve as your choice for surgical intervention.

1. Due to an increase of patients not showing up for their appointments **we will now charge a fee of $50 for not notifying us at least 24 hours prior to your appointment**. This fee will need to be paid prior to any future visits.

2. For surgery patients that fail to show up or notify us of cancellation of their surgery or outpatient procedure there will be a **no show fee of $500.00** and this will need to be paid before any future office or surgery appointments will be made.

3. If you schedule and do not show up for three (3) appointments without valid reason we will discharge you from our care.

4. If you are more than 15 minutes late for your appointment and have not called to notify us that you will be late you will need to be rescheduled if we are unable to work you back into the schedule. If we have a cancellation or another patient that does not show up we can try to work you back into the schedule but that will be at the discretion of the staff.

5. If you are a "work in" patient for an ASAP appointment and you do not show up or if you cancel you will be given the next available appointment which could be 1 to 2 months later.

6. If you require paperwork to be filled out for supplemental insurance, leave for work, or other issues it will take approximately 72 hours to complete as Dr. Selim is only in the office a limited number of days due to his surgery schedule. **There is a $50 charge for all paperwork not including return to work excuses printed by this clinic**.

7. At the start of every new year you will be required to fill out update paperwork as it is state law that we must have updated signatures every new year.

8. If you need a refill, **please give at least 72-hour notice prior to running out of your medication**. If a nurse is not available leave a message with the receptionist for the doctor's approval and a nurse will call you back normally within 72 hours.

9. Please note that Dr. Selim is a surgeon and is not in the office every day, and this at times can cause a delay in the answering of patient messages. Please be patient and we will take care of you to the best of our ability.

10. Due to the various specialties offered by Dr Selim, your office wait time may exceed 2 hours. We thank you for your understanding, as all patients are afforded the necessary time to ensure the best plan of care is provided.

Thank you for allowing our office to participate in your care!

I acknowledge that I have read and understand the above and agree to follow these guidelines to allow for better patient care.

_____ _____

Patient Signature **Date**

_____ _____

Witness **Date**

HEALTH DECLARATION FORM-COVID-19

Patient Name:_____ DOB:_____

MRN:_____ Today's Date: _____

Coronavirus COVID19 is declared a global pandemic by the World Health Organization and has spread across multiple continents infecting tens of thousands across the globe.
The Centers for Disease Control and Prevention (CDC) has made recommendations to physicians and the general public for all patients seeking healthcare to follow recommended protocol.

Patients with a COVID19 infection may look like the cold and flu symptoms, or they may be infectious without any presenting symptoms. Following the CDC patient assessment protocol for early disease detection for patients presenting to the practice, the following criteria is essential for the safety of the patients and healthcare staff.

I attest that I am fully aware of the COVID19 that has impacted the countries healthcare environment and I have made an informed decision to seek healthcare from Dr. Niazy Selim, and I am aware of the risk involved in seeking care in a healthcare setting. I have answered the healthcare questions as thoroughly and honestly as possible. I understand the risk and ramifications of not answering the questions completely honestly including not only putting myself at risk but placing the provider and healthcare staff at risk.

I DO NOT HAVE ANY OF THE FOLLOWING SYMPTOMS:

Upper respiratory infection, cough, cold, flu like symptoms, elevated (fever), difficulty breathing

I, _____ hereby certify, represent and warrant as follows: Within the twenty one (21) days immediately preceding the Date of this Health Declaration Form ("Declaration"),

I HAVE NOT:

a. tested positive or presumptively positive with the Coronavirus or been identified as a potential carrier of the COVID-19 virus or similar communicable illness ("Coronavirus");
b. Travelled outside the country in the last 21 days or regions affected by the virus
c. Experienced any symptoms commonly associated with the Coronavirus;
d. Been in any location positively designated as hazardous and/or potentially infected with the Coronavirus by a recognized health or regulatory authority, such as a country for which the Center for Disease Control and Prevention ("CDC") issued a Level 3 Travel Advisory for Coronavirus;
e. Been in direct contact with or the immediate vicinity of any person I knew and/or now know to be carrying the Coronavirus or has been identified as a potential carrier of the Coronavirus.

I CAN account for all locations visited over the previous twenty one (21) days and shall provide an exhaustive list of all locations visited and modes of transportation used below (please attach an
Additional page as needed):

I AGREE to notify Louisiana Surgeons of Excellence, LLC (by email to naima@lasoemd.com or kat@lasoemd.com or phone: (337) 502-8706 of any change in status, including diagnosis with Coronavirus and/or quarantine, within thirty days either before or following an appointment.

I WILL, if asked, wear a mask (of the specifications recommended by the office personnel) at all times while a patient of Dr. Niazy Selim, and will take all reasonable prophylactic steps that may be recommended by Louisiana Surgeons of Excellence, any relevant public authority.

I WILL consent to having my temperature taken by any representative or staff of Louisiana Surgeons of Excellence prior, during, and after an office visit, and will provide any follow up information reasonably requested by Dr. Selim's office.

I ACKNOWLEDGE and ACCEPT that this Declaration will be considered as my consent to Louisiana Surgeons of Excellence to disclose, share, record and store this Declaration with any relevant authority or service provider for the purposes of ensuring the safety and security of any and all third parties that may come in contact with me prior, during, and after my office visit.

I AGREE to provide a written consent explaining that I understand the potential risks of being seen in the office setting. I understand patient will be triaged over the phone or via telemedicine and managed according to CDC recommendations.

I AGREE there will be a triage station outside the office before staff determine which patient can be managed safely in the office.

POTENTIAL RISKS:

a. There might be any foreseeable risks of getting infected by the virus even if the staff and physician take all precautionary measure to clean and disinfect after each patient by following guidelines of the infection control protocol plan in place.
b. There might be greater risks if you are immunocompromised so let the staff know about your health ahead of times if you have any specific condition.
c. If you believe you are pregnant ensure to let the staff know
d. elderly, those with medical co-morbidities, and potentially other persons who are at higher risk for complications from respiratory diseases, such as pregnant women.

In signing below, I, an individual over the age of 18 of sound mind, knowingly, voluntarily, and freely agree to the terms of this binding Declaration, and in doing so represent the truthfulness and veracity of the above answers.

I have read, or had read to me, the contents of this form and have no further questions. I wish to proceed with visit/care provided by Dr. Niazy Selim and Louisiana Surgeons of Excellence, LLC.

Print Patient Name	*Patient Signature*	*Date*
Print Witness Name	*Witness Signature*	*Date*
Niazy Selim, M.D., Ph.D, F.A.C.S.		
Print Surgeon Name	*Surgeon Signature*	*Date*

Selim Metabolic and Bariatric Surgery Center
GASTROINTESTINAL, MINIMALLY INVASIVE, ROBOTIC AND BARIATRIC SURGERY

NIAZY SELIM, MD, PHD, FACS
215 W. Prien Lake Rd.
LAKE CHARLES, LA. 70601

TEL: (337) 502-8706
FAX: (337) 210-1271
WWW.SELIMSURGERYCENTER.COM

24 Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Louisiana Surgeons of Excellence Physicians reserve the right to charge a fee of $50.00 for all missed appointments ("no shows") and appointments which, absent a compelling reason, are not cancelled with a 24-hour advance notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple "no shows" in any 12-month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____
Print Patient Name *Date*

_____ _____
Patient Signature *Date*

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Greetings,

First, allow me to thank you for allowing our office to participate in your care. We would like to welcome you to our practice.

You will need to contact your insurance carrier. Find out your bariatric benefit. Diagnostic code: E66.01 Morbid Obesity CPT: 43770 Lap Band, 43775 Sleeve Gastrectomy, Roux-en-Y (Gastric Bypass) 43644.

Generally, your insurance carrier will direct you to a website to obtain requirements needed for bariatric surgery authorization. Please provide those details to me. We will be more than happy to assist you in meeting your bariatric requirements.

Should you need additional assistance, please feel free to reach out to me.

Sincerely,

Naima K. Beldjilali

SELIM
SURGERY CENTER

| Naima K. Beldjilali
| Administrator
| Office: (337) 502-8706
| Fax: (337) 210-1271
| Email: naima@lasoemd.com

BARIATRIC SURGERY POLICY

I _____ agree to comply with all bariatric guidelines provided to me from the office of Dr. Niazy Selim. I also agree to obtain a list of requirements needed from my insurance provider in order to be considered for bariatric surgery. I further concede to provide this information to Dr. Niazy Selim's office in a timely manner. I recognize as a bariatric surgery candidate; it is my responsibility to provide all necessary documents required by my insurance provider to Dr. Niazy Selim's office for submission to my insurance provider**. All required pre-operative testing and consultations must be ordered by my primary care physician or my referring physician** (ie: pulmonary function test, sleep study, HbA1c, etc.) I understand my insurance carrier may deem it necessary to have monthly visits with a physician for supervised weight loss, if so; it is my responsibility to make and keep these appointments. Should any appointment be missed, the previous bariatric visits will be negated which will result in the need to restart my bariatric journey.

Tobacco and Nicotine Use:

Bariatric surgery is a lifestyle change. As a bariatric candidate it is imperative that you participate in the success of your weight loss, including prevention and/or early recognition of complications.

I _____ agree to make the necessary commitments, in order to obtain authorization for bariatric surgery. This includes but is not limited to refraining from the use of tobacco/nicotine products including e-cigarettes. I understand the use of tobacco/nicotine negatively effects wound healing. Nicotine, which is found in tobacco, lowers the number of special blood cell components which are needed to help make new tissue along the incision site. Further, nicotine causes the constriction of blood vessels, decreasing the amount of blood flow to injured tissue, delaying the healing process. This increases the risk of ulcers. I have been counseled by Dr. Niazy Selim and his staff on the use of tobacco/nicotine products and have agreed to comply with the TOBACCO/NICOTINE policy.

I _____ **understand if tobacco/nicotine is found during my pre-operative bariatric labs Dr. Niazy Selim reserves the right to cancel my bariatric surgical procedure.**

_____

Patient Signature ***Date***

REQUIREMENTS FROM THE PROGRAM

1. BMI 40 OR Greater
2. BMI 35 OR Greater (you must have comorbid conditions)
3. 6 monthly visits with Dr. Selim (unless your insurance says otherwise)
4. Nutrition (1:1)
5. Nutrition (group with Leslie)
6. 2 Support Group (please provide a proof of attendance by emailing it to us at selimsurgeon@gmail.com)
7. No tobacco use
8. No substance abuse
9. Proof of personal attempts to lose weight for 1 year (have a food journal)
10. Bariatric candidate must lose at least 1%, 10 lbs., or amount of weight specified by the surgeon. (weight should decrease monthly)
11. Documented exercise program. (Candidate must have documentation to present to the insurance carrier.)
12. EGD – esophagogastroduodenoscopy will be performed on every patient prior to their procedure**.**

THINGS THAT MAY BE REQUIRED AFTER YOUR PROCEDURE

(Patient responsible for making the following appointments)

1. Nutrition consult after surgery
2. Psychologist after surgery
3. Appointments with the surgeon will occur as followed:

- 2 weeks post-surgery, 1 month post-surgery, 3 months post-surgery, 6 months post-surgery, 12 months post-surgery
- Annually thereafter

4. Annual lab test will be drawn on all patients excluding those who have undergone laparoscopic gastric banding (Lap-Band) prior to their follow up appointments starting at 3 months.

The above list of requirements is not exhaustive, your insurance carrier might ask you for additional requirements to be completed in order to approve your surgery.

Name: _____ **DOB: ____/____/_____ (MM/DD/YYYY)**

_____

Print Patient Name ***Patient Signature*** ***Date***

_____

Print Witness Name ***Witness Signature*** ***Date***

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MEDIA CONSENT

I authorize **Selim Surgery and Bayou Technology** to interview and photograph me in regard to my participation of the Metabolic and Bariatric Surgery Program.

I hereby authorize the release of my name, telephone number and/or e-mail to other patients or health care providers who are involved in the Metabolic and Bariatric Surgery Program.

I give permission that my pictures, before and after, as well as the above information may be included in the Metabolic and Bariatric Surgery Program website / social media.

Print Patient Name *Patient Signature* *Date*

Print Witness Name *Witness Signature* *Date*

REVOCATION SECTION

I understand that I may revoke this permission at any time by signing the revocation section of this form

_____I hereby revoke this social media permission.

Print Patient Name *Patient Signature* *Date*

Print Witness Name *Witness Signature* *Date*

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MEDIA RELEASE FORM

I grant permission to **Selim Surgery Center** herein after known as the "Media" to use my image (photographs and/or video) for use in Media publications including:

(Check All That Apply)

❑- Videos ❑- Email Blasts ❑- Recruiting Brochures ❑- Newsletters
❑- Magazines ❑- General Publications ❑- Website and/or Affiliates ❑- Other: _____
❑- All Social Media Platforms (YouTube, snapchat, Instagram, …)

I hereby waive any right to inspect or approve the finished photographs or electronic matter that may be used in conjunction with them now or in the future, whether that use is known to me or unknown, and I waive any right to royalties or other compensation arising from or related to the use of the image.

Please initial the paragraph below:

_____ - I am 18 years of age or older and I am competent to contract in my own name.
I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

Name: _____ DOB: ____/____/_____ (MM/DD/YYYY)

_____

Print Patient Name *Patient Signature* *Date*

_____

Print Witness Name *Witness Signature* *Date*

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PATIENT DEMOGRAPHIC SHEET

Today's Date: _____

Patient Name: _____ Birth Date_____ Sex: