EAST HOUSTON SURGICAL ASSOCIATES, P.A.

AUDENCIO ALANIS, M.D.
GENERAL AND BARIATRIC SURGEON

Thank you for choosing Dr. Alanis as your Bariatric Surgeon.

Enclosed are the necessary forms we must have you complete at the time of your initial appointment with Dr. Alanis.

We also have information on the three types of procedures that are performed by Dr. Alanis for Morbid Obesity. He will discuss these options with you at your appointment.

If you have any questions regarding this information, please do not hesitate to bring them up in your session.

To: All Patient and your Family

We would like to make all of our patients and their families aware that our office not only specializes in Weight Loss Surgery but General Surgery as well. Dr. Alanis is Board Certified in Abdominal Surgery. The following are procedures that we can offer:

<u>*Any type of surgery relative to the abdomen including:*</u>

Weight Loss Surgery
Gallbladder Surgery
Hernia Surgery
Appendix Removal
Bowel Surgery
Anti-Reflux Surgical Procedures

Sincerely,

Audencio Alanis, MD

PHONE CONVERSATION LOG

PT. NAME: ______________________________ PHONE NO: _________________

DATE____

AUDENCIO ALANIS, M.D.
GENERAL AND BARIATRIC SURGEON

PERSONAL DETAILS

Name:_________________________________Date:_________________________________

Address:_________________________City/State:_____________________Zipcode:_________

Phone No: (Home)___________________(Cel)___________________(Work)___________________

Date Of Birth:_____________________Age:_______________Marital Status:_________________

SS No. _____________________ TDL No. ________________ Spouse SS No.: ________________

Email Address: ____

Employer/Occupation:____
Address, Telephone: ____

Health Insurance :_________________________ Membership No:__________________________
Address, Telephone: ____ Group No. ___________

Responsible/insured party: ____
Address, Telephone, SS No: ____

CONTACT PERSONS

This information is often vital to us if we need to contact you urgently. Occasionally people move or have new phone numbers and do not let us know.

1. NEXT OF KIN

Name:____Relationship:__________________________

Address:____

____

Telephone No: (Home)__________________________(Bus)________________________________

***Patient Name:*_______________________**

REFERRAL INFORMATION

Referring Doctor:______________________________Date of Referral:______________________

Address:______________________________________Telephone Contact:____________________

Local Doctor:____

Address:______________________________________Telephone Contact:____________________

SOCIAL PROFILE

FAMILY STRUCTURE:

Married: _______ Single: ______ Divorced: _______ Partner/Relationship: _______

Children/Ages:____

____

____

Support persons/friends:____

____

____

Do you have a pet? If so, give details:____

EMPLOYMENT

Are you currently employed?____

Are you full-time, part-time or casual?____

If you are unemployed, what is the reason?____

Are you actively looking for work?____

Has your weight made it difficult to find employment?_____________________________________

Patient Name: _________________________

If employed, please state what level of activity your job involves:

Little (sedentary job) ☐ Moderately active ☐ Very active (Labouring, etc.) ☐

PERSONAL MEDICAL HISTORY

Have you ever suffered with any of the following health problems:

Condition	Yes	No	Details
High Cholesterol	☐	☐	Details:______________________________
Coronary artery disease	☐	☐	Details:______________________________
Congestive heart failure	☐	☐	Details:______________________________
Hypertension	☐	☐	Details:______________________________
Left ventricular hypertrophy	☐	☐	Details:______________________________
Venous stasis ulcers/thrombophlebitis	☐	☐	Details:______________________________
Hyperlipidemia	☐	☐	Details:______________________________
Obstructive sleep apnea	☐	☐	Details:______________________________
Obesity hypoventilation syn.	☐	☐	Details:______________________________
Pulmonary hypertension	☐	☐	Details:______________________________
Asthma	☐	☐	Details: ______________________________
Insulin resistance	☐	☐	Details:______________________________
Type 2 diabetes	☐	☐	Details:______________________________
Polycystic ovarian syndrome	☐	☐	Details:______________________________
Deep venous thrombosis	☐	☐	Details:______________________________
Pulmonary embolism	☐	☐	Details:______________________________
Gastroesophageal reflux disease	☐	☐	Details:______________________________
Hernia	☐	☐	Details:______________________________
Non-alcoholic fatty liver disease	☐	☐	Details:______________________________
Gallstones	☐	☐	Details:______________________________
Stress urinary incontinence	☐	☐	Details:______________________________
Urinary tract infections	☐	☐	Details:______________________________

***Patient Name:*____________________________**

Infertility	Yes	☐	No	☐	Details:___________________________
Miscarriage	Yes	☐	No	☐	Details:___________________________
Fetal abnormalities/mortality	Yes	☐	No	☐	Details:___________________________
Gestational diabetes	Yes	☐	No	☐	Details:___________________________
Degenerative joint disease	Yes	☐	No	☐	Details:___________________________
Back Pain	Yes	☐	No	☐	Details:___________________________
Gout	Yes	☐	No	☐	Details:___________________________
Plantar fasciitis	Yes	☐	No	☐	Details:___________________________
Carpal tunnel syndrome	Yes	☐	No	☐	Details:___________________________
Stroke	Yes	☐	No	☐	Details:___________________________
Pseudotumor cerebri	Yes	☐	No	☐	Details:___________________________
Neurological	Yes	☐	No	☐	Details:___________________________
Depression	Yes	☐	No	☐	Details:___________________________
Anxiety	Yes	☐	No	☐	Details:___________________________
Hepatitis or liver disease	Yes	☐	No	☐	Details:___________________________
Eszema or skin condition	Yes	☐	No	☐	Details:___________________________
Hayfever or rhinitis	Yes	☐	No	☐	Details:___________________________

ARE YOU PRESENTLY UNDER PSYCHIATRIC CARE ?

NO __________ YES __________ (IF YES PLEASE ANSWER THE FOLLOWING)

Date: **Reason:**

____

____

____

HAVE YOU IN THE PAST BEEN TREATED UNDER PSYCHIATRIC CARE?

NO __________ YES __________

Patient Name: ________________________

Date: **Reason:**

____

____

____

HAVE YOU EVER BEEN DIAGNOSED WITH BIPOLOR DISEASE ?

NO ________ YES ________

<u>HAVE YOU EVER BEEN HOSPITALIZED FOR DEPRESSION / ANXIETY / OR FOR SUICIDAL ATTEMPTS:</u>

NO ________ YES ________(Please Explain in Detail Below)

<u>HOSPITALIZATIONS :</u> (FOR DEPRESSION / ANXIETY / SUICIDAL):

Date: **Hospital:** **Reason:**

____

____

____

____

____

____

<u>SMOKING:</u>

Do you smoke? Yes ☐ No ☐ Never ☐ If yes: how many per day? ___________

Have you smoked in the past? ☐ Yes ☐ No

If so, how many per day? ____________________

For how many years? ______________________

When did you stop smoking? ________________

MEDICAL ALLERGIES: Yes ☐ No ☐

If yes, please give details:____

____

***Patient Name:*____________________**

ALCOHOL:

Do you drink alcohol? Never ☐ Rarely ☐ Regularly ☐

How many standard glasses do you drink per day? ______________

How many days do you drink per week? ______________

When do you usually drink? Please check all that apply but circle your main one.

Social occasions ☐ Parties ☐ With meals ☐

Before/after meals ☐ Weekends ☐

If you do not drink alcohol, is there any reason for this? ______________________________

VITAMINS/SUPPLEMENTS:

Do you take multivitamin tablets or other dietary supplements? Yes ☐ No ☐

If yes, how often do you take them?

Rarely ☐ Monthly ☐ Weekly ☐ Most days ☐ Everyday ☐

Please list the multivitamins or other dietary supplements you usually take: ______________

____

Do you take folate tablets? Yes ☐ No ☐

If yes, how often do you take them?

Rarely ☐ Monthly ☐ Weekly ☐ Most days ☐ Everyday ☐

What is the dose? 200 mg ☐ 400 mg ☐

MEDICATIONS

Patient Name: ______________________

Please indicate all medications that you are currently taking

MEDICATION DOSAGE REASON FOR TAKING

SURGICAL HISTORY

DATE: PROCEDURE DOCTOR HOSPITAL & CITY

WEIGHT LOSS HISTORY

PAST ATTEMPTS:		**PLS. DOCUMENT WT. FOR EACH YEAR**
Age obesity began:	________	**2009: _______ lbs.**
Age began first diet:	________	**2010: _______ lbs.**
Greatest single weight loss:	________	**2011: _______ lbs.**
Length of time sustained:	________	**2012: _______ lbs.**
No. of times lost over 25 lbs.	________	**2013:_______ lbs.**

Patient Name:_______________________

WEIGHT LOSS REGIMEN / DIETS

Weight Watchers: Yes ____ No ____ Dates: ______________________________

Jenny Craig: Yes ____ No ____ Dates: ______________________________

Nutrisystem: Yes ____ No ____ Dates: ______________________________

Metabolife: Yes ____ No ____ Dates: ______________________________

Atkins Diet: Yes ____ No ____ Dates: ______________________________

Slim Fast: Yes ____ No ____ Dates: ______________________________

Grapefruit Diet: Yes ____ No ____ Dates: ______________________________

Liquid Diet: Yes ____ No ____ Dates: ______________________________

Optifast: Yes ____ No ____ Dates: ______________________________

TOPS: Yes ____ No ____ Dates: ______________________________

Hypnotherapy: Yes ____ No ____ Dates: ______________________________

Fad diets: ________________________________ Dates: ______________________________

Appetite suppressants: ______________________ Dates: ________________________________

Details of any other weight loss measures (including surgical):

____

____

____

Medically supervised diet or weight control program:

Dates: **Dr. Name** **Program** **Medication**

____

____

____

Was there any particular event that lead to significant weight gain:

____

____

***Patient Name:*_________________________**

FAMILY MEDICAL HISTORY

Do you have a family history of any of the following and if so, please indicate:

	PARENT MOTHER/FATHER	SIBLING BRO./SIS.	GRANDPARENT M-MATERNAL P-PATERNAL	AUNT/UNCLE MA/U-MATERNAL PA/U-PATERNAL
Diabetes				
Heart Disease				
Hypertension				
Gout				
Gallstones				
Obesity				
Snoring/sleep apnea				
Asthma				
Allergies				
Hayfever				
Dermatitis / Eczema				
High Cholesterol				
Osteoporosis				
Hip fractures				

FEMALE - GYNOCOLOGICAL:

LAST GYN EXAM**:** ________________
DOCTOR: __________________
1ST MENSTRATION: ________________
PREGNANCIES: __________________
ACTUAL BIRTHS: __________________

Do you have history of heavy vaginal bleeding: Yes ☐ No ☐

If Yes, please describe ____

____

Do you have regular periods (26 - 33 days) Yes ☐ No ☐

If not, please describe ____

____

Patient Name:______________________

Have you had difficulty in conceiving in the past? Yes ☐ No ☐

Do you currently have problems with infertility? Yes ☐ No ☐

Have you suffered from excess body hair or acne? Yes ☐ No ☐

Have you every been told by a doctor that you have polycystic ovaries? Yes ☐ No ☐

Have you had problems with pregnancy and/or childbirth? Yes ☐ No ☐

If so, in what way ____

____

Have you had a caesarean section? Yes ☐ No ☐

If so, why? ____

SLEEP HISTORY

How many hours sleep do you get a night?______________________________

Is there any thing else that keeps you awake at night? Yes ☐ No ☐

Details:____

Would you consider the quality of your sleep is Good ☐ Fair ☐ Poor ☐

If your sleep is a major problem to you or your partner,would you be prepared to have a sleep study performed now and after you lose weight? Yes ☐ No ☐

SYMPTOMS OF SLEEP APNEA

1. How often do you snore?

   Never _____ Sometimes _____ Always _____

2. Do you wake during the night with a choking feeling?

   Never _____ Sometimes _____ Always _____

Patient Name: ______________________

3. How often would you sleep more than 8 hours in total in a 24 hour period?

Never _____ Sometimes _____ Always _____

4. How often do you wake up more than once during the night?

Never _____ Sometimes _____ Always _____

5. Do you have a headache when you wake up in the morning?

Never _____ Sometimes _____ Always _____

6. Have you noticed a reduction in your libido or sex drive?

Never _____ Sometimes _____ Always _____

7. Do you feel sleepy during the day?

Never _____ Sometimes _____ Always _____

8. Has anyone noticed that you momentarily stop breathing during your sleep?

Never _____ Sometimes _____ Always _____

9. Do you fall asleep while reading?

Never _____ Sometimes _____ Always _____

10. Do you wake up in the morning feeling confused?

Never _____ Sometimes _____ Always _____

11. How often do you have a nap during the day?

Never _____ Sometimes _____ Always _____

12. Do you feel sleepy in the evenings?

Never _____ Sometimes _____ Always _____

Patient Name:_______________________

13. Have you or anyone else noticed a change in your personality recently?

Never _____ Sometimes _____ Always _____

14. How often do you doze off or fall asleep while driving?

Never _____ Sometimes _____ Always _____

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

Use the following table to choose the **most appropriate option** for each situation by placing a tick in the boxes below:

Situation	**[0]** **Never doze**	**[1]** **Slight chance of dozing**	**[2]** **Moderate chance of dozing**	**[3]** **High chance of dozing**
Sitting and reading				
Watching TV				
Sitting, inactive in a public place (e.g. a theatre or a meeting)				
As a passenger in a car for an hour without a break				
Lying down to rest in the afternoon when circumstances permit				
Sitting and talking to someone				
Sitting quietly after a lunch without alcohol				
In a car, while stopped for a few minutes in the traffic				

Patient Name: ______________________

BREATHING HISTORY

Does being at work ever make your chest tight or wheezy?

Yes ☐ No ☐ Details:____

Have you ever had to change your job because it affected your breathing?

Yes ☐ No ☐ Details:____

Have you ever worked in a job, which exposed you to vapours, gas dust or fumes?

Yes ☐ No ☐ Details:____

ASTHMA

Have you ever had asthma? (check one of the following)

Never ☐

Current ☐

In the past ☐

Don't know ☐

Have you ever had to spend a night in hospital because of asthma or breathing problems?

Yes ☐ No ☐

If yes was it in the last 12 months? Yes ☐ No ☐

In the last 12 months, have you visited a hospital casualty department or seen a doctor urgently because you had asthma or breathing problems?

Yes ☐ No ☐ Details:____

In the last 12 months, have you taken a course or prednisolone because of asthma or breathing problems

Yes ☐ No ☐ Details:____

In the last 12 months, have you missed work or school because of asthma or breathing problems?

Yes ☐ No ☐ Details:____

Patient Name:_______________________

COUGH AND SHORTNESS OF BREATH:

Do you usually have a cough?	Yes ☐	No ☐
Do you usually bring up phlegm from your chest when you cough?	Yes ☐	No ☐
Do you get short of breath on exertion?	Yes ☐	No ☐
Do you get short of breath walking on the flat?	Yes ☐	No ☐
Do you get short of breath walking uphill or doing housework?	Yes ☐	No ☐
In the last 12 months, have you had an attack of shortness of breath that came on when you were not exercising and without obvious cause	Yes ☐	No ☐

WHEEZE: a whistling noise that cames from the chest and may cause breathlessness or difficulty in breathing

In the last 12 months, have you had wheezing in your chest?	Yes ☐	No ☐
In the last 12 months, have you had an attack of wheezing that came on after you stopped exercising?	Yes ☐	No ☐
In the last 12 months, have you had a feeling of tightness in your chest on waking in the morning?	Yes ☐	No ☐

ACTIVITY LEVEL ~ What exercise do you do on a regular basis?

How many sessions of exercise (walking, sports, etc.) do you do per week for more than 30 minutes at a time? ________________________

What sort of activities? ____

How do you feel when exercising? Please mark level on scale:

0____10

Awful *Average* *Excellent*

Patient Name:______________________

GASTRO ESOPHAGEAL REFLUX / INDIGESTION

Do you have a history of heartburn or indigestion

Yes ☐ No ☐ Details:____

If yes, how often do you have reflux during the day?

Many times/day ☐ Daily ☐ Most days ☐ Most weeks ☐ Occasionally ☐

Do you suffer heart burn / indigestion during the night? If so how oftern

Many times/night ☐ Nightly ☐ Most nights ☐ Most weeks ☐ Occasionally ☐

What aggrevates or causes your reflux? Details: ___________________________________

____

Do you have difficulty swallowing?

Yes ☐ No ☐ Details:____

Does food ever get stuck?

Yes ☐ No ☐ Details:____

Does food or fluid reflux into the mouth?

Yes ☐ No ☐ Details:____

Do you vomit with reflux?

Yes ☐ No ☐ Details:____

Do you suffer from recurrent sore throats?

Yes ☐ No ☐ Details:____

Patient Name:______________________

Do you suffer from a hoarse voice?

Yes ☐ No ☐ Details:____

Do you suffer from a regular cough at night?

Yes ☐ No ☐ Details:____

Please list any treatments you may use for reflux/heartburn or indigestion:

____

____

____

Patient Name:_______________________

EAST HOUSTON SURGICAL ASSOCIATES, P. A.
AUDENCIO ALANIS, M.D.

INFORMED CONSENT AGREEMENT FOR SLEEVE GASTRECTOMY SURGERY

STATE LAW REQUIRES THAT YOU BE INFORMED ABOUT YOUR CONDITION AND THE RECOMMENDED SURGICAL, MEDICAL, OR DIAGNOSTIC PROCEDURE TO BE USED SO THAT YOU MAY ACTIVELY PARTICIPATE IN THE DECISION WHETHER OR NOT TO UNDERGO THE PROCEDURE AFTER KNOWING THE RISKS AND HAZARDS INVOLVED. THIS DISCLOSURE IS NOT MEANT TO SCARE OR ALARM YOU. BUT IS SIMPLY AN EFFORT TO MAKE YOU BETTER INFORMED SO YOU MAY PARTICIPATE IN THE DECISION OR WITHHOLD YOUR CONSENT TO THE PROCEDURE.

CONSENT

I voluntarily request Audencio Alanis, M.D. as my physician and such associates and technical assistants as he may deem necessary, to treat my condition which has been explained to me as: EXOGENOUS MORBID OBESITY.

____

_

I understand that the following surgical, medical and/or diagnostic procedures are planned for me and I voluntarily consent and authorize these procedures: **Sleeve Gastrectomy** procedure to reduce food intake, and if necessary, x-ray, EKG, and multiple blood tests. If medically indicated and my gallbladder is diseased, I consent to the excision of the diseased organ. Also, if a hiatal, umbilical, ventral, or other hernia is found, I consent to the repair of such hernia if Dr. Alanis deems it necessary to be done at the time of surgery.

The risks of such surgical and other procedures have been explained to me. I also understand that if a condition is found present that warrants cancellation of the surgery per Dr. Alanis, the surgical procedure will not be performed as stated.

I understand that my physician may discover other or different conditions, which may require additional or different procedures than those planned. I authorize my physician, Dr. Alanis, and his associates and technical assistants to perform such other procedures, which are advisable in their professional judgment. I **(do, do not)** consent to the use of blood and blood products as deemed necessary. I do consent to the administration of anesthesia, and the performance of pathology and radiology services.

I understand that no warranty or guarantee has been made to me as to results and cure. There is no guarantee or assurance that desirable weight loss will be maintained, no guarantee or assurance that the staple line will not become disrupted thus causing a greater capacity for food tolerated.

Just as there are risks and hazards in continuing my present medical condition uncorrected, there are also risks and hazards attendant to the performance of the surgical, medical, and/or diagnostic procedures. Risks include, but are not limited to: bleeding from the suture line (0-6.4%), gastric leak from the suture line (1-1.4%), excess narrowing or post-op stricture (1-2%), pouch dilation over time (5-10%), post-op nausea (usually 2 weeks duration), post-op heartburn (10%), pulmonary problems, ulcer, post surgical hemorrhage, bowel obstructions, incisional hernias, kidney failure, peritonitis, loss of spleen and/or death.

I have been given the opportunity to ask questions about my condition and the associated risks, the procedures to be used and the risks and hazards involved. Alternative forms of treatment such as dieting, diet medications, and other weight loss surgical procedures have been explained to me, as well as the risks of no-treatment. I believe that I have sufficient information to give this informed consent.

I certify this form has been fully explained to me, that I am _______ years of age, that I have attended school for ________ years, that I have read, or if I cannot read to me, that the blank spaces have been filled in, and that I understand its consents.

DATED: _____________________________ TIME: _______________________

_______________________________________ _____________________________

Patient/Other Legally Responsible Person Sign Print Name

WITNESS:

____

Signature

EAST HOUSTON SURGICAL ASSOCIATES, P.A.
AUDENCIO ALANIS, MD

POST-OPERATIVE AFTERCARE AGREEMENT

I, the undersigned that participation in a surgical weight loss program requires me to adhere to my post-operative schedule of follow-up office visits and routine laboratory test or any other tests which my physician deems necessary and in the best interest of my health.

I understand that my post-operative physician's visits will be free of charge until my third month visit.

I understand that Dr. Alanis's office staff will, if necessary, help me to coordinate or schedule the required laboratory tests that are ordered.

For Gastric Bypass RNY patients only, laboratory tests will be ordered at your 3 month, 6 month, and 12 month visits, followed by annual laboratory and bone density testing.

Lap Band Adjustments are billed when they occur. Global period does not apply.

Below is the recommended schedule for post-operative visits. And additional follow-up visits with Dr. Alanis, will be on a case by case basis. Laboratory tests may be ordered at the physician's request.

SCHEDULE OF OFFICE VISITS:

GASTRIC BYPASS: 2WEEKS, 6 WEEKS, 3 MONTHS, 6 MONTHS, 12 MONTHS, 18 MONTHS, 24 MONTHS, AND THEN YEARLY UP TO 5 YEARS

GASTRIC SLEEVE: 2WEEKS, 6 WEEKS, 3 MONTHS, 6 MONTHS, 12 MONTHS, 18 MONTHS, 24 MONTHS, AND THEN YEARLY UP TO 5 YEARS

LAPAROSCOPIC BAND: 2WEEKS, 6 WEEKS, 3 MONTHS, 6 MONTHS, 12 MONTHS, 18 MONTHS, 24 MONTHS, AND THEN YEARLY UP TO 5 YEARS

NO TRAVELING OUT OF TOWN IS ALLOWED DURING THE FIRST MONTH FOLLOWING WEIGHT LOSS SURGERY. IF A PATIENT DOES TRAVEL OUT OF TOWN THEY ARE TRAVELING AT THEIR OWN RISK AND AGAINST MEDICAL ADVISE.

I agree to the provisions set forth above.

______________________________ ________________________

Patients Signature Date

AUDENCIO ALANIS, M.D.

GENERAL AND BARIATRIC SURGEON

713-455-5531 Fax 713-455-4321

Authorization of Release of Medical Information

(Please Print) Last First Middle Name

Other names used by this patient (Married/Maiden) in the past 5 years

Address City, State Zip Code

Date of Birth Social Security Number Phone Number

I hereby authorize:

____

____

____

To furnish medical information to: **AUDENCIO ALANIS MD**
201 Enterprise Ave Suite 100
League City, Texas 77573
Phone: (713) 455-5531
Fax: (713) 455-4321 or (281) 538-1170

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED:

______ Request of the Individual ______ Continuity of Care ______ Treatment

_______ Complete Medical Record
_______ H & P
_______ Operative Reports
_______ Lab and X-Ray Reports
_______ Psychiatric Reports
_______ ER Reports
_______ Discharge Summary
_______ Consultations
_______ Substance Abuse/ ETOH Abuse
_______ Other

Where applicable, please specify date (s) for information to be release:

In some circumstances, release of medical information may require an additional authorization.

_______ HIV test results _______ Psych Records _______ Substance Abuse Records

The undersigned is entitled to a copy of this form upon request

Patient Signature Date

Patient Representative Date

EAST HOUSTON SURGICAL ASSOCIATES, P.A.
AUDENCIO ALANIS, MD

PHYSICIAN LIST OF PAST HISTORY

Most insurance companies require not only for you to presently meet certain weight requirements but also to show that your past history also met certain weight requirements.

Please list for us any of the following to help us to obtain the needed information:

1. Any doctor you may have seen in the past several years that weighed you.
2. Any hospital admit or ER admit that shows your documented weights.
3. Any supervised weight loss program that may have weighed you.

Name __________________________ Phone__________________Fax_________________

Name __________________________ Phone__________________Fax_________________

Name __________________________ Phone__________________Fax_________________

Name __________________________ Phone__________________Fax_________________

Name __________________________ Phone__________________Fax_________________

AUDENCIO ALANIS, M.D.
East Houston Surgical Associates, M.D.
Financial Responsibility Statement

Our primary mission is to provide you with quality, cost effective medical care. Together we are trying to adapt to the way that health care is financed and delivered. We at East Houston Surgical Associates think it is important to make sure there is a good understanding with our patients regarding patient and insurance financial responsibility. We hope this explanation will be helpful to you with respect to this.

You must present your insurance card at each visit.

You must pay the copay, deductible, or coinsurance at the time of service, unless arrangements have been made in advance with the office manager.

If you receive services that are not covered by your plan or you are no longer insured, you will be expected to pay for your services at the time in which services are rendered.

We will gladly bill your insurance company for any remaining balance.

Should an insurance company send you the check for your services rendered, and you did not pay for the services in full, then you are responsible for sending the check and explanation of benefits to our office.

If your insurance company does not pay the claim within 90 days, then we will expect payment from you.

In circumstances where we have a participating provider agreement with your insurance company for an agreed upon negotiated rate for our services, an adjustment will be made in the amount if the difference between this rate and our normal fees at the time we receive payment from your insurance company.

Your insurance may refuse payment of a claim for the following reasons:
This is a pre-existing illness that is not covered by your plan.
You have not met your full calendar year deductible.
The type of medical services required is not covered by your plan.
Your health care was not in effect at the time of services.
You have other insurance that must be filed first.

In regards to adjustments, we will bill your insurance company. If your claim is denied as non-covered for this procedure, you will be responsible for the self pay rate of $200.00.

Please understand that financial responsiblility for medical services rest between you and your health plan. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitations in coverage that may be included in your plan. If your health plan denies your claim for any of these or other reasons, our office cannot be responsible for this bill. It is your responsibility as a patient to pay the denied amount in full.

We value you as a patient, and our first priority is to provide you with the best possible health care.

I have read and understand my obligations and I acknowledge that I am fully responsible for payment of any services not covered or approved by my insurance carrier(s).

____________________________________ ____________________

Patient's Signature Date

Revised 12/13

EAST HOUSTON SURGICAL ASSOCIATES, P.A.
AUDENCIO ALANIS, MD

Confirmation of History & Physical Intake Data

I hereby affirm that the information regarding my medications, surgeries, hospitalizations, chief medical complains, family history, personal history and dietary attempts, including, but not limited to medically and non-medically supervised programs, contained in the Intake forms furnished to me by Dr. Alanis, and to the best of my knowledge and recollection the information set forth therein is true, accurate and correct.

I understand that this information will be used by Dr. Alanis to process my insurance pre-determinaton request with my insurance carrier. Furthermore, I understand that providing false or erroneous information could nullify my insurance claim and subject me to penalties of perjury or insurance fraud, or both.

____ __________________

Patient's Signature Date

INITIAL CONSULT/ PROGRAM WORK UP AGREEMENT

Patient Name: _____________________

Date: _____________________

We will bill your insurance company for the Initial Consultation/ Program work up visit fees of Dr. Alanis. If you have not met your deductible you will be responsible for paying any consultation fees prior to your surgery date.

I AGREE TO THE ABOVE TERMS,

____ __________________

Patient's Signature Date

EAST HOUSTON SURGICAL ASSOCIATES, P. A.
AUDENCIO ALANIS, M.D.

Acknowledgement of Review of
Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

____

Signature of Patient or Personal Representative

____

Date

____

Name of Patient or Personal Representative

____

Description of Personal Representative's Authority

EAST HOUSTON SURGICAL ASSOCIATES, P. A.
AUDENCIO ALANIS, M.D.

CONSENT FOR THE RELEASE OF CONFIDENTIAL INSURANCE INFORMATION

I authoriz my medical insurance company, to disclose to the employee or representatives of EAST HOUSTON SURGICAL ASSOCIATES, P.A. any and all documentation and/ or information regarding my medical coverage, including, but not limited to, the terms of my policy, my benefits, and any other pertinent or relevant information.

________________________________ ____________________

Patient's Signature Date

INSURANCE INFORMATION

We will be happy to assist you with the insurance forms. In order to do so, we will need all the current information of your insuance health plan at each office visit. If you are a member of any insurance program in which we participate in, we will file your claim for you. Patients will be responsible for any deductibles and co-payments or non-covered services at the time of the visit.

AFTER 60 DAYS IT IS PATIENT'S RESPONSIBILTY TO PAY THE BALANCE OF THE ACCOUNT EVEN IF THERE IS AN INSURANCE CLAIM PENDING. WE WILL NO LONGER BE RESPONSIBLE FOR COLLECTING YOUR INSURANCE CLAIM OR FOR NEGOTIATING SETTLEMENT ON A DISPUTED.

This form is a written notification that you have been informed.

The doctor will only perform services that are medically reasonable and necessary for your well being.

I authorize payment of medical benefits to East Houston Surgical Associates, P.A., (Audencio Alanis, MD) for the services provided.

________________________________ ____________________

Patient's Signature Date

EAST HOUSTON SURGICAL ASSOCIATES, P. A.
AUDENCIO ALANIS, M.D.

IMPORTANT
Immediate Action Strongly Advised

Following your initial consultation, your physician will most likely order some laboratory test and diagnostic clearances. Unless the insurance company requires these tests, we will not delay in processing your request for predetermination of benefits.

Be ready! It is very common for the insurance company to deny request for treatment of morbid obesity unpon the first submission. As explained by the intake specialist, with your permission, we will appeal any denial. If a denial is received, the insurance company requires the appeal to be filed within thirty (30) days. At this point, the insurance company will also be requesting additional information. This may include, but is not limited to, the results of any test or diagnostic clearances that your physciain ordered. This is only one reason you should **immediately schedule your test or clearances.** Should you incur any problems or delays in scheduling these test or clearances, please contact us. We will do everything possible to help you.

It is important for you to understand that whether or not you intended to proceed with obesity surgery, the results of any tests or diagnostic clearances will be helpful in managing your health issues.

If you have not fully documented your diet history, please begin to gather this information and return it to our office.

Remember!!! Your case can not be successfully appealed with the requested information.

Help us help you!!

____________________________________ ________________
Patient's Signature Date

EAST HOUSTON SURGICAL ASSOCIATES, P.A.
AUDENCIO ALANIS, M.D.

AFFIDAVID

I am at least 18 years of age and can state that I am desirous of undergoing surgical intervention for my severe obesity. Both conservative and non-conservative weight loss approaches for the treatment of morbid obesity have been thoroughly explained to me.

I hereby acknowledge that I have been examined and counseled by the physician, whose name appears on the History and Physical attached hereto; I have also been or will be evaluated by a licensed professional counselor, psychologist or psychiatrist before the proposed surgical treatment is performed.

I thoroughly understand that surgical intervention for morbid obesity requires a commitment and willingness on my part to participate in a long-term follow-up program and, to increase the success rate of the surgical procedure; I have been advised that I will need to participate in an aftercare support group or seek private counseling.

I am aware that the proposed surgical treatment is a **tool** and not a cure of morbid obesity. I have executed a consent agreement, a copy of which is also attached hereto. The Consent Agreement will attest to the fact that I understand that surgery can result in complications and even in death.

I hereby affirm that the information regarding m chief medical complaints, medications, surgeries, family medical history, personal background and dietary attempts, including, but not limited to, medically and non-medically supervised programs contained in the History and Physical attached hereto, was prepared from the information that I personally furnished to the medical provider, and to the best of my knowledge and recollection the information set forth therein is true, accurate and correct.

Since many of the actual records are currently unavailable to me and since it would put me to an inordinate amount of time and expense to secure these records, I trust that is sworn affidavit will be accepted in lieu thereof.

I understand that providing false or erroneous information could nullify my claim and subject me to penalties of perjury or insurance fraud, or both.

____________________________________ __________________

Patient’s Signature Date

EAST HOUSTON SURGICAL ASSOCIATES, P.A.
AUDENCIO ALANIS, M.D.

ASSIGNMENT OF BENEFITS

Please be advised, that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payments. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charges. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance company.

After 60 days it is the patient's responsibility to pay the balance of the account even if there is an insurance claim pending. We will no longer be responsible for collecting your insurance claim or negotiating settlement on a disputed.

We will be happy to assist you with your insurance forms. In order to do so, we will need all the current information of your insurance health plan at each office visit. If you are a member of any insurance program in which we participate in, we will file your claim for you.

This form is a written notice that you have been informed.

I hereby assign all medical and/or surgical benefits to include major medical and basic benefits to which I am entitled including Medicare, private insurance, and other health plans to:
EAST HOUSTON SURGICAL ASSOCIATES, P.A.
AUDENCIO ALANIS, M.D.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize said assignee to release all information necessary to secure payment.

____________________________________ ____________
Patient's Signature Date

____________________________________ ____________
Insured Signature Date