Freeman Bariatric Center

Online Seminar Instructions

1. Have primary care provider referral w/chart notes faxed to Freeman Bariatric Center: 417-347-5107

2. freemanhealth.com/Bariatric, Scroll and click Helpful Resources Tab (middle of page), there is a video and bariatric packet (below video). Click on Video to watch, and then fill out ENTIRE bariatric packet. ****All of this paperwork gets turned into insurance anything that applies left incomplete can affect entrance into bariatric program.****

3. **Copy of State ID and Front and Back copy of Insurance Card MUST be turned in with bariatric packet**. If emailing make sure bariatric packet is in pdf format, and pictures in jpg format, attach them both to the email and send to: bariatric@freemanhealth.com, or if mailing: Freeman Bariatric Center 3302 McIntosh Circle Suite 1 Joplin, MO 64804

4. **Bariatric Packet CANNOT be filled out on a phone.** You can call the office 417-347-1266 and have packet mailed to your address. PHOTOS of packet are NOT accepted by insurance.

5. Processing of bariatric packet once received takes 4-6 WEEKS, ANYTHING INCOMPLETE OR MISSING DELAYS THIS.

6. Another option is to attend a Freeman Seminar Please call 417-347-1266 for more info

REQUIREMENTS:

-MUST BE NICOTINE FREE- INSURANCE WILL REQUIRE TESTING

-MARIJUANA IS NOT RECOMMENDED IT WILL PREVENT WEIGHT LOSS

-IF DIABETIC MUST HAVE A1C UNDER 8 TO BE ELIGIBLE FOR SURGERY.

-MUST BE ABLE TO TRANSPORT TO JOPLIN FOR ALL APPOINTMENTS.

-NUTRITION CLASSES ARE NOT COVERED BY INSURANCE. CLASSES ARE SELFPAY, EACH CLASS HAS SEPARATE COST MINIMUM # OF CLASSES IS 4 (SOME INSURANCE COMPANIES REQUIRE MORE), MUST HAVE PAYMENT AT TIME OF SERVICE. FIRST CLASS: $263, ALL OTHER CLASSES $166.50 *EACH*. PRICES SUBJECT TO CHANGE WITHOUT NOTICE. **You can call your insurance and see if any of the classes are covered 1st class cpt code:97802 all other classes cpt code:97804**

-WILL NEED A REFERRAL FROM PCP, KEPT FOR 30 DAYS, THEN DISCARDED

-MUST BE ABLE TO BUDGET FOR PROTEIN SHAKES (WILL BE ON FOR MONTHS) AND BARIATRIC VITAMINS (WILL BE TAKING FOR LIFE).

- IF YOU NO CALL NO SHOW TO ANY SCHEDULED APPOINTMENT YOU WILL BE ADDED TO THE NOT PROCEEDING LIST.

-INSURANCE RENEWALS FOR ANY MEDICAID MUST BE UP TO DATE FOR ELIGIBILITY/BENEFITS. IF NOT RENEWED NO BENEFITS CAN BE GIVEN.

****ANY DOCUMENTS MISSING OR NOT FILLED OUT CAN STALL PROCESSING AND AFFECT INSURANCE ELIGIBLITY****

Freeman Health System Bariatric Center

PATIENT INFORMATION (Please Print) Date: _____

Preferred Procedure: Gastric sleeve____ Roux-en-Y (Bypass)_____ Duodenal Switch_____

First Name: _____ Middle Intl: ____ Last Name: _____

Address: _____

City/State/Zip: _____ Sex: M F Status: S M D W Ht: _____ Wt: _____

Race: □ Black, African American □ Asian □ White □ American Indian, Alaska Native
□ Native Hawaiian, other Pacific Islander □ Unknown □ Declined

Ethnicity: □ Hispanic/Latino □ Not-Hispanic/Latino □ Declined □ Unknown

Primary Language: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Age: _____ SSN: _____-_____-_____

Employer: _____ Employer's Address: _____

Phone: _____ Position (Job Title): _____ Length of Employment: _____

PRIMARY CARE PHYSICIAN

Doctor's Name:_____

Address: _____

Phone: _____ Fax: _____Specialty:_____

How were you referred to the program? _____

CO-OCCURING MEDICAL ISSUES

Please answer all questions related to your current and/or past medical history.
Place an 'X' beside Yes or No for *every* question.

Cardiovascular Disease	Yes	No
High Blood Pressure		
Congestive Heart Failure		
Ischemic Heart Disease		
Heart Stress Test		
Heart Attack		
Stents Placed in Heart		
Heart Catheterization		
Anginal Chest Pain		
Peripheral Vascular Disease		
Stroke		
Lower Leg Edema/Swelling		
Blood Clot in Leg or Lung		
Vena Cava Heart Filter		
Coagulation/Bleeding disorders		
Cardiologist		

RN/MD Notes (for office use only)_____

_____
_____
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_____

Name: _____
Address: _____
_____
Phone: _____

Patient Initials: _____

REV 2/25

Freeman Health System Bariatric Center

	Yes	No	
Metabolic Disease			
Diabetes Mellitus Type I	☐	☐	
Diabetes Mellitus Type II	☐	☐	
Fasting glucose > 99 mg/dL	☐	☐	
Oral Medication for Diabetes	☐	☐	
Insulin Use	☐	☐	
Eye/Kidney Problems	☐	☐	
High Cholesterol or Lipids	☐	☐	
Gout/High Uric Acid Levels	☐	☐	
Endocrinologist	☐	☐	Name: _____ Phone: _____ Address: _____
Pulmonary	Yes	No	
Sleep Study	☐	☐	
Sleep Apnea	☐	☐	
COPD	☐	☐	
CPAP/BIPAP Use	☐	☐	
Oxygen Use at Home	☐	☐	
Pulmonary Hypertension	☐	☐	
Asthma	☐	☐	
Inhaler Use Due to Asthma	☐	☐	
Pulmonologist	☐	☐	Name: _____ Phone: _____ Address: _____
Gastrointestinal	Yes	No	
Heartburn/Reflux/GERD	☐	☐	
Heartburn Medication Use	☐	☐	
Past Anti-Reflux Surgery	☐	☐	
Barrett's Esophagus Crohn's	☐	☐	
Disease or Colitis Gallstones	☐	☐	
Gallbladder Removal	☐	☐	
Abnormal Liver Tests	☐	☐	Name: _____ Phone: _____ Address: _____
Musculoskeletal	Yes	No	
Back Pain	☐	☐	
Back Pain Requiring Meds	☐	☐	
Hip, Knee, Ankle Pain	☐	☐	
Joint Pain Requiring Meds	☐	☐	
Fibromyalgia	☐	☐	
Joint Replacement	☐	☐	
Back Surgery	☐	☐	
Orthopedist	☐	☐	Name: _____ Phone: _____ Address: _____
Reproductive (Female)	Yes	No	
Polycystic Ovarian	☐	☐	
Syndrome Infertility	☐	☐	
Menstrual Irregularities	☐	☐	
Hysterectomy	☐	☐	
Gynecologist	☐	☐	Name: _____ Phone: _____ Address: _____
General	Yes	No	
Stress Urinary Incontinence	☐	☐	
Sanitary Pad Use for Leakage	☐	☐	
Pseudotumor Cerebri	☐	☐	
Abdominal Hernia	☐	☐	
Hernia Repair	☐	☐	
Walk with a Cane/ Walker	☐	☐	
Sores/Rash in Skin Folds	☐	☐	
Past Weight Loss Surgery	☐	☐	
Type of Weight Loss Surgery: _____			Surgery Location: _____ Address: _____ Phone: _____

Patient Initials: _____

FAMILY HISTORY of medical problems (parents, grandparents, siblings, aunts and uncles).

Please mark all that apply

___High Blood Pressure
___Heart Disease or Heart Attack
___Cancer
___Diabetes
___Stroke
___Obesity
___Bleeding Disorder
___Clotting Disorder

EXERCISE

Do you have any physical limitations that make it difficult or impossible for you to exercise? Y N

Do you have difficulty with basic mobility or self-care? Y N

Do you use any of the following assistive devices? Y N

If yes, please check all that apply:

□ Cane or walker
□ Wheelchair or mobility scooter
□ Crutches or brace
□ Prosthetic device
□ Oxygen

MEDICATIONS Currently Taking (Include prescriptions, OTC, vitamins and herbs)

Name	Dose	Frequency	Purpose	Start Date

Patient Initials:_____

List **ANY RECENT** labs, x-rays, EKGs, stress tests or echocardiograms with date and location.

_____

_____

_____

_____

ALLERGIES to medications, latex or other substances

Substance	Reaction to substance (rash, breathing, etc.)

List any **SURGERY** (Please write 'Lap' if done laparoscopically)

List **ANY OTHER** medical problems/surgeries not listed above:

_____

_____

_____

_____

_____

Patient Initials:_____

Freeman Health System Bariatric Center

DIET HISTORY

Weight History in past 5 years (Highest weight each year, in pounds)

_____ _____ _____ _____ _____

How many years have you been overweight?_____

How many years have you been trying to lose weight? _____

How long have you been researching or thinking about weight loss surgery?_____

Why are you seeking weight loss surgery? _____

_____

What has been your lowest adult weight?_____ Highest adult weight?_____

Do you have any religious or cultural beliefs that affect what you eat? Y N

If yes, describe_____

Please fill out the diet history form completely, with as much detail as possible. The information on this form is used for your Medical Necessity letter that is submitted to your insurance company. Documentation should reflect ALL weight loss efforts attempted, including physician supervised, commercial programs, prescription diet pills, behavior modification, unsupervised diets and over-the-counter diet aids.

What diets have you tried in the past? _____

_____

_____

_____

REV 2/25

Patient Initials:_____

MENTAL HEALTH AND READINESS FOR SURGERY QUESTIONS

PLEASE RESPOND TO ALL ITEMS

1. Have you been hospitalized for any psychiatric reason (i.e., suicide attempt, severe depression. etc.)
   a. Within the past 12 months? YES NO
   b. In the past 2 years? YES NO
   c. In the past 5 years? YES NO

2. In the last 12 months, have you experienced **(circle one)**
   a. Auditory hallucinations YES NO
   (i.e., do you hear voices other people cannot hear?)
   b. Visual hallucinations YES NO
   (Ii.e., do you see things that other people cannot see)

3. Have you ever been **diagnosed with and/or treated for** mental or emotional concerns including **(circle all that apply)**
   a. Depression/mood disorder
   b. Anxiety/panic disorder
   c. Eating disorders
   d. Schizophrenia/schizoaffective disorder
   e. Alcohol or substance use disorder
   f. memory impairment

   If **yes** to any, please list the name of the provider or organization, dates you were treated and diagnosis (if you are aware of it)

   _____
   _____
   _____

4. Have you ever done any of the following to lose weight: **(please list if past or current)**

   a. Purge (i.e., self-induced vomiting) YES NO PAST CURRENT
   b. Use laxatives or diuretics YES NO PAST CURRENT
   c. Engage in excessive exercise YES NO PAST CURRENT
   (i.e., over 1 hour a day)

5. If applicable please list the name and organization of the mental health provider/psychiatrist/nurse practitioner who prescribes your mental health medications.

   _____

Patient Initials:_____

Please complete the following.

Alcohol use: ☐ None ☐ Rare (1-2/month) ☐ Occasional (3 or less/week) ☐ Frequent (4+/week)

Tobacco use: ☐ None ☐ Rare (1-2/month) ☐ Occasional (3 or less/week) ☐ Frequent (4+/week)

☐ Packs per day (Cigarettes) ☐ Chew Y N If no, when did you quit? _____

☐ E-cigarette ☐ Nicorette Gum

Substance Abuse: Y N

If yes, describe substance_____ Quit Date_____

☐ Marijuana ____Cocaine ____Crack ____Meth

☐ Other recreational drug _____

Do you have any religious or cultural beliefs that affect what you eat? Y N

If yes, please describe_____

Patient Initials:_____

Test Questions for Online Bariatric Seminar

1. Freeman Bariatric Center is a Comprehensive Program meaning:
    a. A program that includes nutrition, psychological support and support groups
    b. Availability of services before and after surgery
    c. Required both by the program and insurance requirements
    d. All of the above
2. Freeman Bariatric Center is a Center Of Excellence accredited program through the MBSAQIP?
    a. True
    b. False
3. Comorbidities that insurance may acknowledge may include:
    a. Hypertension (high blood pressure)
    b. Diabetes-Type 1 and Type 2
    c. Sleep Apnea
    d. All of the above
4. Who is a candidate?
    a. At least 18yrs old
    b. BMI (body mass index) 35 with associated comorbidity conditions or a BMI of 40 or greater
    c. Must be able to walk
    d. Approved through evaluation with nutrition and psychiatric counselor
    e. All of the above
5. Identify the types of bariatric surgeries offered at Freeman Bariatric Center:
    a. Sleeve Gastrectomy (VSG)
    b. Roux-en-Y (Gastric bypass)
    c. Duodenal Switch (SADI)
    d. All of the above
6. A liquid diet is followed before surgery for how long?
    a. 2 weeks
    b. 1 week
    c. 3 weeks
    d. All of the above
7. Risks following any Bariatric surgery can include:
    a. Bleeding
    b. Infection
    c. Injury to the staple line causing a leak
    d. All of the above
8. Nutrition requirements may include:
    a. One-on-one session
    b. Group sessions
    c. Personal goals set with nutritionist
    d. All of the above
9. After Bariatric surgery changes must include:
    a. Making the protein portion of your meal the first priority

b. Not using straws
c. Making hydration a priority
d. Taking vitamin supplements
e. Not drinking fluids 30 minutes before and 30 minutes after a meal
f. All of the above

10. Disciplinary habits to begin practicing include which of the following:
    a. Not using straws
    b. Chewing food thoroughly
    c. Logging you food and water intake
    d. Starting an exercise regimen
    e. All of the above
11. The purpose of the psychological evaluation is:
    a. To access your readiness for Bariatric surgery
    b. Ability to identify any mental health risk factors
    c. To help you be successful
    d. All of the above
12. The results of the evaluation can be:
    a. Cleared
    b. Denied
    c. Conditionally Cleared with recommendations
    d. All of the above

FREEMAN Health System

NEW PATIENT/UPDATE

Date of Birth: _____

PATIENT INFORMATION: (Please Print)

First Name: _____ Middle Intl: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____ Misc. Phone 1: _____ Preferred Contact Method: _____

Email: _____ Preferred Statement Method: (E) Electronic (P) Paper

Date of Birth: _____ Age: _____ S.S#: _____ - _____ - _____ SEX: M F Marital Status: S M D W

Race: ☐Unknown ☐Black, African American ☐Asian ☐White ☐American Indian, Alaska Native ☐Native Hawaiian, Other Pacific Islander ☐Other Primary Language: _____

Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Unknown

Employer: _____ Employer's Address: _____

Employer's Phone: _____ Position (Job Title): _____ How long employed?: _____

If Minor, Patient lives with: MOTHER / FATHER / GRANDPARENT / FOSTER PARENT / OTHER_____(circle one)

PERSON TO NOTIFY IN THE EVENT OF AN EMERGENCY: (Other than below)

Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____

PERSON RESPONSIBLE FOR BILL: (If Minor, Parent or Guardian)

Name _____ S.S. #: _____ - _____ - _____ Date of Birth: _____

Relationship to Patient: _____ Address: _____

Phone: _____ Mobile Phone: _____ Email: _____

Employer: _____ Employer's Address: _____

Employer's Phone: _____ Position (Job Title): _____ How long employed?: _____

SPOUSE INFORMATION:

Name: _____ SS#: _____ - _____ - _____ Date of Birth: _____

Phone: _____ Mobile Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Employer's Address: _____

Employer's Phone: _____ Position (Job Title): _____

INSURANCE INFORMATION:

PRIMARY INSURANCE NAME: _____ ID#: _____ Group#: _____

Subscriber Name: _____ Employer: _____ Date of Birth: _____ SS#: ____ - ____ - ____

SECONDARY INSURANCE NAME: _____ ID#: _____ Group#: _____

Subscriber Name: _____ Employer: _____ Date of Birth: _____ SS#: ____ - ____ - ____

TERTIARY INSURANCE NAME: _____ ID#: _____ Group#: _____

Subscriber Name: _____ Employer: _____ Date of Birth: _____ SS#: ____ - ____ - ____

REFERRED BY: _____ **REFERRING PHYSICIAN:** _____

☐ **I acknowledge that I have had the opportunity to read and/or receive a copy of System's Notice of Privacy Practices. A complete copy Of the Notice is available at the Admissions desk.**

Patient or Guardian's Signature: _____ Date: _____

Authorization for Release of Information

roi@freemanhealth.com

All sections of this authorization form MUST be completed to be valid in accordance with 42 CFR Parts 160 and 164

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code _____

Phone: _____ Maiden or other names: _____

I request my protected health information (PHI) be released from:

Clinics ↓
[ ] Cornell-Beshore Cancer Institute
[ ] Freeman Heart Institute
[ ] Freeman Midwest Orthopedics
[ ] Freeman Nephrology and Dialysis
[ ] Freeman Wound Care

Hospitals ↓
[ ] Freeman Hospital East and West
[ ] Freeman Neosho Hospital
[ ] Occumed

ER and Urgent Care ↓
[ ] Emergency Room (Joplin and/or Neosho)
[ ] Urgent Care - Joplin
[ ] Urgent Care - Webb City

[ ] **Other** (Specific Provider Location / Provider Name/ or Doc Type): _____

I request my protected health information (PHI) be released to:

Name: Freeman Bariatric Center Email: bariatric@freemanhealth.com

Address: 3302 McIntosh Circle Suite 1 Phone: 417-347-1266

City/State: Joplin, MO Zip Code: 64804 Fax (immediate purposes only): 417-347-5107

*** I authorize the following PHI to be released from my medical record(s):**

[ ] Abstract/Pertinent Summary*
* dictated reports and test results
[ ] Complete Medical Record (all pages)
[ ] Emergency Room Record
[ ] Laboratory Reports
[ ] Radiology Reports
[ ] Itemized Billing
[ ] UB-04 Claim Form
[ ] 1500 Claim Form

[ ] **Other**: _____

Covering the period of health care from:

[ ] Specific Date(s): _____ to _____

Purpose for requesting information:

[ ] Legal [ ] Insurance
[ ] Personal [ ] Continuation of Care

How Information is to be received (if not marked, paper is default)

[ ] US Mail - paper format
[ ] CD - Secure electronic format
[ ] Fax (immediate purposes only)
[ ] Pick up copies in the Department
[ ] Email

By signing this authorization form, I understand that:

* Requests for copies of medical records and/or non-document material may be subject to copying fees.
* I have the right to revoke this authorization at any time. Revocation must be made in writing and presented to the Medical Records Department at 1102 W. 32nd Street, Joplin, MO 64804. Revocation will not apply to information that has already been released in response to this authorization.
* Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____.
If I fail to specify an expiration date/event/condition, this authorization will expire within 90 days of the date signed.
* Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether or not I sign this authorization.
* Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

*** I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug related conditions, alcoholism, psychiatric/psychological condition, psychiatric/mental health treatment and or HIV related conditions. Patient Initial Here: _____**

*** I authorize the release of any info. pertaining to genetic testing to the person or organization described above. Patient Initial Here: _____**

Patient/ Authorized Representative Signature: _____ Date: _____

Printed Name of authorized Representative: _____ Relationship to Patient: _____

Witness Signature: _____ Date: _____

If signed by a patient's authorized representative, supporting legal documentation must accompany this authorization form

* R O I *

Freeman Bariatric Center Check List:

- Referral sent(must be less than one month old)
- Packet filled out completely
- ROI filled out completely
- Test Questions filled out(watch seminar for answers)
- Copy of Current ID Front Side
- Front and Back Copy of Insurance Card
- Mail everything above back to addressed envelope included

*** Do NOT schedule this until AFTER Initial Nutrition Class has been COMPLETED***

Local Organizations for Bariatric Psychological Evaluations

Applied Psychological Services, P.C.

Jennifer Alberty, PSYD
1627 W. 26th St.
Joplin, MO 64804
Ph. (417) 627-9601
Fax (417) 627-9032
Hours: Mon-Fri 8am-9pm
Insurance: Employer/Commercial, Medicaid, Medicare, Private pay, EAP; discounted/sliding fee schedule available for cash pay

Community Health Center

Brock Boekhout, PHD Psychology
3011 N. Michigan St.
Pittsburg, KS 66762
Ph. (620) 231-9873
Fax (620) 231-5062
Hours: Mon-Fri 8am-5pm
Accepts Insurance

Restore Counseling Center

Heather Wadeson
600 W Republic Rd. Suite A116
Springfield, MO 65807
Ph. (417) 319-6076
Fax (417) 374-7158
Hours: Mon-Fri 10am-5pm
Cash Pay Only