Valley Bariatric PLLC

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Patient Demographic Information Sheet

PATIENT

NAME (LAST, FIRST, MIDDLE)					**SOCIAL SECURITY NUMBER**
DATE OF BIRTH	**AGE**	**SEX** M F	**LANGUAGE** English Spanish __ Other: _____		**PRONOUNS**
RACE AND ETHNICITY Asian Black or African American American Indian or Alaskan Native Native Hawaiian or Other Pacific Islander White Hispanic or Latino Other: _____ Decline to specify					
ADDRESS			**CITY, STATE**		**ZIP CODE**
TELEPHONE	**CELL PHONE**		**OTHER PHONE**		**OCCUPATION**
EMAIL ADDRESS					
EMERGENCY CONTACTS	**NAME AND RELATION TO PATIENT**				**PHONE**
	NAME AND RELATION TO PATIENT				**PHONE**
PRIMARY/FAMILY PHYSICIAN	**PHONE**		**REFERRING PHYSICIAN**		**PHONE**
PHARMACY	**PHARMACY PHONE**		**PHARMACY ADDRESS**		

PRIMARY INSURANCE		**SECONDARY INSURANCE**	
INS. CO. NAME		**INS. CO. NAME**	
MEMBER ID #	**GROUP #**	**MEMBER ID #**	**GROUP #**
RELATIONSHIP TO PATIENT		**RELATIONSHIP TO PATIENT**	
INSURED'S NAME		**INSURED'S NAME**	
INSURED'S SS#	**DOB**	**INSURED'S SS#**	**DOB**

I GIVE MY PERMISSION FOR THESE INDIVIDUALS TO OBTAIN MY PROTECTED HEALTH INFORMATION

NAME	**DATE OF BIRTH**	**RELATION TO PATIENT**	**PHONE**

****May we leave messages regarding appointments on your answering machine? Yes No**
****May we text you regarding appointments Yes No **May we email you? Yes No**

I have received a copy of the Privacy Rules from this provider and authorized the above list of persons who may receive my Protected Health Information. I may revoke this at any time by giving written notification to this provider.

SIGNATURE _____ **DATE** _____

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Medical History Form

NAME: _____ **Ht**: ____'____" **Wt**: _____ **lbs.**

What is the reason for today's visit? _____
Please describe details of condition: _____

How long, how often? _____
How severe, causes? _____
Contributing factors? _____
_____

MAJOR MEDICAL EVENTS /PAST SURGERIES	Where/When	Doctor

Ongoing Medical Conditions for which you see a doctor or take medication.			
Bleeding Disorders	High Blood Pressure	☐ Cancer (Type) -	☐ High Cholesterol
Sleep Apnea, CPAP Y/N	Heart Disease	☐ Thyroid	☐ Binge Eating Disorder
Acute infections	Atrial Fibril ation	☐ Asthma	☐ PCOS
Diabetes, Type1/Type 2	DVT/PE	☐ Pacemaker/defibrillator	☐ Infertility
Reflux/GERD	Stroke	☐ Stents (specify)-	
Seizures:	COPD	☐ Other (specify) -	

CURRENT MEDICATIONS	
Medication	**Dose**

ALLERGIES		
Medication	**Reaction**	**Severity**
		Mild Mod Severe
		Mild Mod Severe
		Mild Mod Severe
		Mild Mod Severe
		Mild Mod Severe
		Mild Mod Severe

Last Mammogram: _____ Normal: ☐Yes ☐ No
Last Colonoscopy: _____ Normal: ☐Yes ☐ No

Social History

Marital Status: Single Married Divorced/Legally Separated Widowed Life partner
Use of alcohol: Never Rarely Moderate Daily
Use of cigarettes: Never Previously, but quit Yes - Current packs per day ____
Use of drugs: __ Never Type/Frequency _____

Family Medical History- List ONLY if they had or have significant diseases or conditions			
Disease	**Deceased**	**Disease**	**Deceased**
Father:	__Y N	Siblings:	Y __N
Mother:	__Y __N	Children:	Y __N

SIGNATURE_____ **DATE:** _____

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Systems Review

Name: _____ Date: _____

Please circle if you have or have had any of the following:

General
Recent weight change
Fevers/chills
Fatigue
Night sweats

Skin and Hair
Rashes/sores
Skin cancers/melanomas
Hair loss
Unusual lumps under skin

Endocrine
Diabetes
Thyroid disease
High blood pressure

Ear, Nose & Throat
Glasses/contacts
Double vision
Hearing loss
Persistent ringing in ears
Difficulty swallowing
Pain or stiffness in neck
Fullness in the neck or throat
Hoarseness or voice change

Lungs
Shortness of breath
Emphysema or chronic bronchitis
Asthma or wheezing
Congestive heart failure
Persistent cough
Pneumonia

Blood
Anemia
Blood transfusions
If yes: when, how much, and why
_____

Heart and Blood Vessels
Heart attacks
Chest pain
Heart murmur
Heart surgery
Irregular heart beat (palpitations)
Swelling in the feet
Phlebitis or blood clots
High blood pressure

Gastrointestinal
Difficulty swallowing
Heartburn
Hiatal hernia
Ulcer disease
Hepatitis or other liver disease
Jaundice
Colitis
Irritable bowel disease
Crohns' disease
Constipation
Diarrhea
Hemorrhoids/rectal disorders
Blood in stool
Abdominal pain

Musculoskeletal
Arthritis
Joint pain, stiffness or swelling
Decreased muscle strength
Osteoporosis
Any broken bones
Back pain/back surgery

Neurological
Headaches
Dizziness/fainting
Weakness or tingling in arms/legs
History of any head trauma

Infectious
Any serious infection
Childhood illnesses: measles
mumps chicken pox
Last tetanus _____ Last flu shot
_____

For Women Only
Abnormal bleeding or discharge
Any gynecological surgery
Pain during intercourse
Kidney stones
Urinary tract infections
Sexually transmitted disease (gonorrhea, herpes, venereal warts, HIV, AIDS)
Age at time of first period _____
Number of pregnancies _____
Number of live births _____
Did you breast feed your children?
_____
Average how long? _____
Last menstrual period _____

Breasts
Breast pain
Nipple discharge
Breast lumps
Previous breast surgery
Changes in breast size

For Men Only
Kidney stones
Prostate disease
Difficulty urinating
Urinary tract infections
Vasectomy
Sexually transmitted disease (gonorrhea, herpes, venereal warts, HIV, AIDS)

If you circled any of the above, please explain.

_____
_____
_____
_____
_____

Any other Issues or concerns:

_____
_____
_____

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

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Please Provide a List of all active physicians treating you:

Name	Specialty	Reason	City/State
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

For Weight Loss Patients:

What is your motivation for weight loss?:

What diet/exercise have you tried in the past? When?:

☐Keto ☐Red Mtn Other: _____
☐Intermittent Fasting ☐Calorie Restriction
☐Weight Watchers ☐Low Carb
☐Jenny Craig ☐Diet/Exercise

Have you ever tried Medication for weight loss?:
☐ Yes ☐ No

Name of Medication: _____
Date Taken: _____
Weight loss achieved: _____
Side effects: _____

Name of Medication: _____
Date Taken: _____
Weight loss achieved: _____
Side effects: _____

Have you ever had your hormones tested?
☐ Yes ☐ No Mo/Year: _____
If yes, were they normal? ☐Yes ☐ No ☐n/a
If not normal, were you treated? ☐Yes ☐No What treatment: _____

Are you currently following a diet? ☐Yes ☐ No if so, what diet? _____
Do you have any food restrictions? _____
Are you currently able to exercise? ☐Yes ☐ No
If no, what are you restrictions: _____
If yes, what kind, duration, frequency of exercise: _____

Highest Adult Weight: _____
Lowest Adult Weight: _____

Valley Bariatric PLLC (VB PLLC) Prescription Refill Policy

Due to the widespread abuse/dependence of oral prescription narcotics and their implication in the overdose deaths of thousands of Americans every year, our practice and many others are establishing practice guidelines to minimize narcotic prescriptions in the routine care of our surgical patients. We are focusing on alternative and multi-modality treatment strategies to combat this epidemic.

VB PLLC does not provide long-term pain management services. If long-term pain management is required, you will be referred to a pain management physician or your primary care physician.
If you are on chronic narcotics from a pain management physician, you will need to receive your post-operative pain medicine from that physician.

Initial Prescription: You may receive a pain medication prescription (sent electronically) immediately following your surgical procedure to treat post-operative pain. We do not send narcotic prescriptions in advance of surgery. Prescriptions are written for an appropriate amount of tablets and the expected number of days you may need them, based on your type of surgery.

Refills: Refills of your post-operative narcotic pain medication may be sent electronically based on your physician's discretion. These will typically only be refilled maximum 1 time and within a 2 week period following surgery. Medications are to be taken according to directions. No early refills will be granted.

Routine refill requests will only be authorized between 8am – 5am, Monday – Thursday, and between 8am – 2:00pm on Fridays. Routine refill requests will be denied after hours, during the weekend, or on Holidays. Refills requested during these times will be referred to the Emergency Room.

The Arizona State Board of Pharmacy monitors each physician's prescribing record on a quarterly basis. Physicians are required by law to query all patients receiving a prescription for a controlled substance.

Are you able to take a schedule II medication? (Examples of Schedule II narcotics include: hydromorphone (Dilaudid®), methadone (Dolophine®), meperidine (Demerol®), oxycodone (OxyContin®, Percocet®), and fentanyl (Sublimaze®, Duragesic®), morphine, opium, codeine, and hydrocodone
☐Yes ☐No

Patient's Printed Name: _____

Patient's Signature: _____ Date: _____

Do you have a pain management specialist?
☐Yes ☐ No

If Yes, please provide Name and office address:

_____

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Patient Email/Texting Informed Consent Form:

Risk of using email/texting: The transmission of client information by email and/or texting has a number of risks that clients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:

- Email and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- Email and text senders can easily misaddress an email or text and send the information to an undesired recipient. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
- Employers and on-line services have a right to inspect emails sent through their company systems.
- Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
- Email and texts can be used as evidence in court.
- Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

Conditions for the use of email and texts:

Valley Bariatric PLLC cannot guarantee, but will use reasonable means, to maintain security and confidentiality of email and text information sent and received. Valley Bariatric PLLC is not liable for improper disclosure of confidential information that is not caused by Valley Bariatric PLLC intentional misconduct. Patients/Parent's/ Legal Guardians must acknowledge and consent to the following conditions:

- Email and texting is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time. Email and text messages should not be time sensitive.

- Email and texts should be concise. The patient/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.

- Email and text messages may be filed into your medical chart.

- Valley Bariatric PLLC will not forward patient's/parent's/legal guardian's identifiable emails and/or texts without the client's/parent's /legal guardian's written consent, except as authorized by law.

- Patients/parents/legal guardians should not use email or texts for communication of sensitive medical information. Valley Bariatric PLLC is not liable for breaches of confidentiality caused by the patient/parent/ legal guardian or any third party.

- It is the patient's/parent's /legal guardian's responsibility to follow up and/or schedule an appointment if warranted.

Patient Acknowledgement and Agreement:
I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the use of email and/or text messaging as a form of communication between Valley Bariatric PLLC and me. I consent to the conditions and instructions outlined, as well as any other instructions that Advanced Surgical Associates may impose to communicate with me by email or text.

Patient Name: _____ Email: _____

Patient Signature: _____ Date: _____

NOTICE OF PRIVACY POLICY FOR PROTECTED HEALTH INFORMATION (PHI)

The office of Valley Bariatric PLLC; Maria R Brown, M.D. is dedicated to protect your "nonpublic personal health information". This notice is to tell you how and why we collect that information, and who has access to that information.

HOW WE COLLECT YOUR INFORMATION:
Your personal demographic information such as name, address, birth date, social security number, and medical insurance information is obtained from you. This is why we ask you to fill out the patient information sheet and why we ask for a copy of your insurance card. This ensures that the information we collect is correct.

If you came to our practice through a hospital encounter, we may obtain that information from the hospital. However, on your first visit to this office, we will ask you to fill out our information sheet to ensure that the information we received from the hospital was correct.

We may also ask a doctor or other health care provider who referred you to this practice to give us health information that will enable us to better treat your medical condition. This benefits you in that we will have test results that have already been obtained by the referring entity.

WHY WE COLLECT THIS INFORMATION:
We collect this information so that we can treat your medical condition and obtain payment from you or your health insurance.

MAINTAINING ACCURATE AND TIMELY INFORMATION:
To ensure that the information we maintain is accurate, each time you visit this office you will be asked if any of your information needs to be updated.

WHO HAS ACCESS TO THIS INFORMATION:
Any person or persons you designate in writing, people directly involved in your medical care, people creating and maintaining your medical record, and those entities that need your information to process health care claims and obtain payment for our services have access to your Protected Health Information.

Entities such as Government Oversight agencies, Judicial and Administrative Proceedings, Law Enforcement Agencies, Coroners and Medical Examiners, and Organ Procurement Organizations may obtain copies of your Protected health Information. These entities are mandated by Law and this practice has no jurisdiction over such entities.

HOW WE PROTECT YOUR INFORMATION:
We release your information only to those people who need your information. We maintain physical, electronic, and procedural safeguards so that no one but persons involved in your healthcare or entities who need this information for claims processing have access to your Protected Healthcare Information.

**We participate in an organized health care arrangement consisting of greater Phoenix metropolitan area hospitals as well as physicians who have medical staff privileges at one or more of these hospitals. Participants in this arrangement work together to improve the quality and efficiency of the delivery of healthcare to their patients. As a participant in this arrangement, we may share your PHI with other members of this arrangement for purposes of treatment, payment or the health care operations of this organized health care arrangement.

YOUR RIGHTS:
You have the right to inspect your Protected Healthcare Information. You also have the right to amend any errors you may find in your record.

If you leave this practice, your Protected healthcare Information will continue to receive the protection outlined in this notice.

COMPLAINT/COMMENTS:
If you have any complaints concerning our privacy practices, you may contact the Secretary of the Department of Health and Human Services, at 200 Independence Avenue, S. W. Room 509F, HHH Building, Washington D.C. 20201. You also may contact the Privacy Officer of this practice at (480)926-6653.

THIS PRACTICE reserves the right to amend our privacy policy as dictated by law, without sending you a copy of the amendment. Any changes to this policy will be posted in our office.

This notice is effective as of July 1, 2024

_____
Patient Name (Print)

_____ **Date:**_____
Patient Signature

No Show Policy

As a specialty office, we see a high volume of patients that require extra time and consideration. Many of our patients wait an extended period of time for appointments and procedure/surgery bookings. It is important to Valley Bariatric PLLC & Dr. Maria Brown to respect the valuable time of our patients, providers, and staff. We understand that Emergencies can happen. Please ensure you call to cancel your appointments appropriately. Please review and initial our policy below:

In the event of a no show/no call appointment, you will be charged a fee of $25.00
Patient Initials: _____

Two no show/no call office visits may result in termination from the practice
Patient Initials: _____

In the event of a No Show to a Procedure/Surgery or a cancellation within 2 business days of your scheduled procedure, you will charged a fee of $250.00
Patient Initials: _____

A No Show to a Procedure/Surgery will result in termination from the practice
Patient Initials: _____

By signing below, you acknowledge our no show and cancellation policy and may be charged the above fees. If you have payment on file, you will be charged automatically as indicated. Thank you for your consideration.

_____
Print name

_____
Signature

_____
Date