



**Sidney P. Rohrscheib, M.D.**

Thank you for your interest in the Illinois Bariatric Center. Should surgery be the best approach to managing your weight, we guarantee our commitment to personalized and quality care. Our physicians, nurses, dieticians and staff prepare patients carefully before surgery. We believe this comprehensive preparation helps us meet your expectations after surgery.

The rest of this document explains the steps you will go through before your surgery is scheduled. Please carefully read the enclosed materials that outline the criteria for having weight loss surgery and how the surgeries are routinely performed at the Illinois Bariatric Center.

It is crucial that you complete the personal health data forms. Insurance companies rely heavily on this information for approval of surgery. **Please carefully complete the enclosed sheets and bring them, along with any insurance information, to your initial consult.** It is our goal to make this process as easy and trouble-free as possible. If you have questions that are not answered in this information, please do not hesitate to call us.

**We now have 5 locations in Illinois to serve you better! Call our toll-free number to make an appointment at any of our convenient locations.**

**Illinois Bariatric Center – Champaign**

Olympian Surgical Suites  
1002 Interstate Drive  
Champaign, IL 61822

**Illinois Bariatric Center – Carthage**

Specialty Clinic  
1450 N. CR 2050  
Carthage, IL 62321

**Illinois Bariatric Center – Clinton**

803 Illini Drive  
Clinton, IL 61727

**Illinois Bariatric Center – Mt. Vernon**

Neuromuscular Orthopedic Institute  
302 Broadway Street  
Mt. Vernon, IL 62864

**Illinois Bariatric Center – Robinson**

Crawford Memorial Hospital Consulting Clinic  
1000 N. Allen Street  
Robinson, IL 62545

**SIDNEY ROHRSCHEIB, MD**  
**PATIENT REGISTRATION**

Date: \_\_\_\_\_

Patient: \_\_\_\_\_ **Sex:** Male / Female  
*(First)* *(Middle Initial)* *(Last)*

Cell Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Home Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Patient SS#: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**Race:** White African American Hispanic American Indian Pacific Islander

**Marital Status:** Single Married Widowed Separated Divorced Partner

Employed by: \_\_\_\_\_ Occupation: \_\_\_\_\_

Business Address: \_\_\_\_\_ Business Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

**PRIMARY INSURANCE COVERAGE**

Policy Holder: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Employed by: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_\_ Policy Holder's SS#: \_\_\_\_\_

**SECONDARY INSURANCE COVERAGE**

Policy Holder: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_\_ Policy Holder's SS#: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relation: \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

How did you hear about our program? Please circle and describe all that apply.

**TV Commercial** \_\_\_\_\_ **Newspaper/Magazine** \_\_\_\_\_ **Seminar** \_\_\_\_\_

**Internet:** Obesityhelp.com \_\_\_\_\_ LapBand.com \_\_\_\_\_ RealizeBand.com \_\_\_\_\_ ASMBS.org \_\_\_\_\_

IllinoisBariatricCenter.com \_\_\_\_\_ Other Website: \_\_\_\_\_

**Radio:** \_\_\_\_\_ **Friend/Relative:** \_\_\_\_\_

**Physician Referral:** \_\_\_\_\_ **Other:** \_\_\_\_\_

# Financial and Privacy Policies

*Please read and initial where indicated*

## CONSENT TO TREAT

I hereby authorize employees and agents; include physicians, physician assistants, nurse practitioners; of this medical office to render routine medical care to the patient indicated on this form, obtain medical history, and to fulfill the orders of the physicians; including consultants, associates and assistants of the physician's choice. \_\_\_\_\_

## HIPAA AUTHORIZATION

For further explanation or for a copy of our full HIPAA Privacy Notice please see the front desk staff or visit our website. This release is effective until revoked by patient with written signature.

**Please Mark Appropriate Section Below:**

**No Restrictions**      **Restrictions (please list your requested restrictions below)**

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I give my permission to release my medical information and lab results to the following persons:

*This will remain in effect, until revoked in writing, by patient.*

Name	Relationship
_____	_____
_____	_____
_____	_____

## FINANCIAL AGREEMENT

- It is your responsibility to inform our office of any address, telephone number or insurance changes. You may be responsible for additional charges if your primary insurance is terminated during your medical care.
- Your account is to be kept current- accordingly all self-pay or insurance co-payments, co-insurances and deductibles will be collected at the time of service. Payable by cash, check, Visa or MasterCard.
  - Past due accounts will be assigned to a collection agency; if you are concerned about the status of your account or would like to discuss it with our Office Manager please let us know.
  - If your account is turned over to a collection agency, you will be responsible for all reasonable fees necessary for the collection of the delinquent account including, but not limited to, collection agency fees of 50% of the balance due and costs and reasonable attorney's fee of 33% of the balance.
- We will submit your insurance claims. However, **WE MUST EMPHASIZE THAT AS MEDICAL PROVIDERS, OUR RELATIONSHIP IS WITH YOU NOT YOUR INSURANCE COMPANY.** We attempt to verify your benefits but encourage you to do the same.
  - Not all services are a covered benefit with all insurance plans.
  - It is YOUR responsibility to be aware of what service(s) is being provided to you and if it is a covered benefit under your insurance policy.
  - You are responsible for any non-covered charges not payable by your insurance company
  - Although filing your insurance claims is a courtesy extended to you, all charges are always your responsibility.
  - We realize that temporary financial problems may affect timely payment; we urge you to contact us promptly for assistance should a problem arise.

## NOTICE REGARDING EMAIL COMMUNICATION

- We are happy to communicate with you electronically regarding appointment times, status checks, etc. We are working constantly to ensure our network is safe, but please be aware, if our network or email systems were to ever be breached your private health information could be accessed & viewed by unauthorized persons. If you do not consent to electronic communications, please notify the office.

**I CONSENT TO HAVING MY PICTURE TAKEN FOR CHART MONITORING PURPOSES:** \_\_\_\_\_

**I CONSENT TO HAVING MY INSURANCE VERIFIED FOR BENEFIT COVERAGE OF THE GASTRIC BAND:** \_\_\_\_\_

The above information is accurate and complete to the best of my knowledge and I authorize release of information to obtain precertification for surgery and file a claim with my insurance company. I will not hold my doctor or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*typed name serves as signature*

# MEDICAL INFORMATION

**Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Do you have or have had any of the following (check all that apply):

- |   |  |
|---|--|
| <input type="checkbox"/> Diabetes                             | <input type="checkbox"/> Stroke                                |
| <input type="checkbox"/> High Blood Pressure                  | <input type="checkbox"/> Pancreatitis                          |
| <input type="checkbox"/> High Cholesterol                     | <input type="checkbox"/> Cancer                                |
| <input type="checkbox"/> Heart Disease                        | <input type="checkbox"/> Ulcers, Where? _____                  |
| <input type="checkbox"/> Have you had sleep study?            | <input type="checkbox"/> Crohns Disease, Colitis               |
| <input type="checkbox"/> Sleep Apnea, CPAP _____ BiPAP _____  | <input type="checkbox"/> Hernia                                |
| <input type="checkbox"/> Reflux or Heartburn                  | <input type="checkbox"/> Urine Incontinence                    |
| <input type="checkbox"/> Degenerative Joint Disease/Arthritis | <input type="checkbox"/> Thyroid Disease                       |
| <input type="checkbox"/> Blood Clots in Legs or Lung          | <input type="checkbox"/> Depression                            |
| <input type="checkbox"/> Asthma                               | <input type="checkbox"/> Anorexia/Bulimia                      |
| <input type="checkbox"/> Shortness of Breath with Activity    | <input type="checkbox"/> Laxative Use for Weight Loss          |
| <input type="checkbox"/> Lung Disease                         | <input type="checkbox"/> Infertility                           |
| <input type="checkbox"/> Gallbladder or Liver Disease         | <input type="checkbox"/> Menstrual Irregularities              |
| <input type="checkbox"/> Leg/Ankle Swelling                   | <input type="checkbox"/> Polycystic Ovarian Syndrome           |
| <input type="checkbox"/> Hip, Back or Knee Pain               | <input type="checkbox"/> Skin Fold Irritation/Yeast Infections |

## Family History

## Who?

- |   |   |
|---|---|
| <input type="checkbox"/> High Blood Pressure _____          | <input type="checkbox"/> Stroke _____     |
| <input type="checkbox"/> High Cholesterol _____             | <input type="checkbox"/> Cancer _____     |
| <input type="checkbox"/> Heart Disease _____                | <input type="checkbox"/> Depression _____ |
| <input type="checkbox"/> Asthma or Lung Disease _____       | <input type="checkbox"/> Arthritis _____  |
| <input type="checkbox"/> Gallbladder or Liver Disease _____ | <input type="checkbox"/> Diabetes _____   |
| <input type="checkbox"/> Other _____                        |   |

Previous Surgeries:

Date:

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Allergies to medication or latex? (If yes, what type of reaction do you have?)

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Do you smoke/vape? Yes \_\_\_ No \_\_\_ If so, how much? \_\_\_\_\_ for how long? \_\_\_\_\_

Do you drink any alcoholic beverages? Yes \_\_\_ No \_\_\_ If so, how much? \_\_\_\_\_ how often? \_\_\_\_\_



# PHYSICIAN LIST

**Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Please list information on your current primary care physician and ALL PREVIOUS PHYSICIANS within the past 5 years.

*Providing us with a phone number and a fax number for medical records will greatly speed up the process of obtaining your records.*

PHYSICIAN NAME	SPECIALTY	CITY	PHONE #	FAX #

If you choose to seek preauthorization for surgery, we will need to obtain medical records from all pertinent physicians. As this may be a timely process, you may wish to obtain your records prior to your visit. If you would like for us to obtain your records, we will have you sign release forms after your initial consultation.

