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 3 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 – Clinton 803
Illini Drive
Clinton, IL 61727

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 ☐ Other

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Seperated ☐ 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)**

_____

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 <u>NOT</u> 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 COVERAGE OF WEIGHT LOSS SURGERY: ☐_

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):

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

Family History **Who?**

- ☐ High Blood Pressure _____
- ☐ High Cholesterol _____
- ☐ Heart Disease _____
- ☐ Asthma or Lung Disease _____
- ☐ Gallbladder or Liver Disease _____
- ☐ Other _____
- ☐ Stroke _____
- ☐ Cancer _____
- ☐ Depression _____
- ☐ Arthritis _____
- ☐ Diabetes _____

Previous Surgeries: Date:

_____

_____

_____

_____

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

_____

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? _____

Do you or have you used illicit drugs? Yes ☐ No ☐ If so, what? _____

How much? _____How long?_____

IBC MEDICATION LIST

Patient Name: _____ **Date of Birth: _____**

List medications taken on a regular basis. Include ALL over-the-counter and any herbal medications

MEDICATION	DOSAGE (Mg)	Reason for taking medication	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	
CPAP USE: Y ☐ N ☐															
Reviewed by:															

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.

DIET HISTORY

Name: _____ ***Date:*** _____

Current Weight: _____ Height: _____

Goal (Desired) Weight:._____ Weight at age 18: _____

1. **Record ALL weight loss attempts within the past few years**, *especially professionally supervised (physician and/or registered dietitian) programs*.
   Also, be sure to include attempts that were not professionally supervised**.**
2. Start with most recent diet and work backward from there. You may make additional copies or. use another sheet.
3. If you were on weight loss medications, what type of food plan were you following (low fat, 1,200 calorie, etc.) in addition to taking the drug?

Do NOT leave this sheet blank

YEAR	LENGTH OF TIME ON DIET	WEIGHT LOST ON DIET	TYPE/NAME OF DIET	IF SUPERVISED, NAME OF DOCTOR OR DIETITICIAN