

Valley Bariatric PLLC

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Patient Demographic Information Sheet						
NAME (LAST, FIRST, MIDDLE)				SOCIAL SECURITY NUMBER		
DATE OF BIRTH	AGE	SEX ___ M ___ F	LANGUAGE ___ English ___ Spanish ___ Other: _____		PRONOUNS	
P A T I E N T	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** _____

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.			
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Cancer (Type) -	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Sleep Apnea, CPAP Y/N	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Binge Eating Disorder
<input type="checkbox"/> Acute infections	<input type="checkbox"/> Atrial Fibril ation	<input type="checkbox"/> Asthma	<input type="checkbox"/> PCOS
<input type="checkbox"/> Diabetes, Type1/Type 2	<input type="checkbox"/> DVT/PE	<input type="checkbox"/> Pacemaker/defibrillator	<input type="checkbox"/> Infertility
<input type="checkbox"/> Reflux/GERD	<input type="checkbox"/> Stroke	<input type="checkbox"/> Stents (specify)-	
<input type="checkbox"/> Seizures:	<input type="checkbox"/> COPD	<input type="checkbox"/> Other (specify) -	

CURRENT MEDICATIONS	
Medication	Dose

ALLERGIES		
Medication	Reaction	Severity
		__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:** _____

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: _____

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

Have you ever tried Medication for weight loss?:

- Yes No
- | | |
|-----------------------------|-----------------------------|
| Name of Medication: _____ | Name of Medication: _____ |
| Date Taken: _____ | Date Taken: _____ |
| Weight loss achieved: _____ | Weight loss achieved: _____ |
| Side effects: _____ | 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:

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)

Patient Signature

Date: _____

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 for your office visit, you will be charged a fee of \$50.00 Patient Initials: _____

Two no show/no call office visits may result in termination from the practice and a fee for each missed appointment. 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