

Horizon Surgical, P.C.

1890 Alabama Hwy. 157

POB II, Suite 420-B

Cullman, AL 35058

Bariatric Program

Phone: (256) 736-BAND

Fax: (256) 736-2265

Dear Patient,

Thank you for your interest in Horizon Surgical's Bariatric Program. You are entering the first of several steps toward exploring whether Bariatric Surgery is the right treatment plan for you.

At Horizon Surgical, P.C., we continuously strive to provide the highest quality care possible.

The path of Bariatric Surgical Treatment is a partnership between our Practice and you. It requires diligence and commitment from us both.

The first step in pursuing Bariatric Surgery is to attend a free informational seminar. After attending the seminar, you may call our office to schedule an appointment for a physician consultation. Please bring this completed packet for the physician consultation appointment. Also, please bring a copy of your medical records for the last three years. We look forward to seeing you.

Sincerely,
Horizon Surgical, P.C.



Financial Information

Thank you for expressing an interest in the Horizon Surgical Bariatric Program. This page is intended to introduce you to the process of determining your financial ability to obtain Bariatric Surgery in our program.

➤ Surgical Fee

- Patients with Insurance: As per insurance allows
- For patients without insurance a set fee of **\$4,000.00** (excluding complications) is available. This fee is for Horizon Surgical, P.C. only. You will encounter additional fees from the hospital, etc.

We do accept Visa, MasterCard, American Express, and all Debit Cards.

Prior to surgery you will have 3 visits (discussed in more detail below). Your first visit will be a mandatory educational seminar (free of charge) hosted by Dr. Kevin Cottingham. If you wish to proceed you will then call to make an appointment to have an in-office consult with Dr. Cottingham at a cost of \$150.00 If approved for surgery, you will have a pre-op visit with Dr. Cottingham at a charge of \$75.00

- I agree and understand that I am fully responsible for coinsurance, copays, and any amount not covered by my insurance carrier, regardless of what type of insurance coverage I have.
- I understand that Horizon Surgical, P.C. will attempt to precertify my surgery with my insurance company. I also understand that this process may take up to 8 weeks to complete, depending on my personal coverage in accordance with my policy. I understand that I may not be approved at all for surgery.
- There will be a \$150.00 charge for the in-office consultation that is non-refundable.
- If approved for surgery, I will have a pre-op visit with Dr. Cottingham in the office before scheduling the surgery. This visit will cost \$75.00
- I am aware that I will be asked to return (post-operatively) and continue follow-up visits. Depending on my personal situation, other care may be necessary. That will be determined by the physician. If you are a Private Pay (cash) patient, your post op visit/adjustments will be covered for 12 months. After your 12 months, the visits will be \$55.00. If you are insured patient, your post op visit will be covered for 90 days after the date of surgery. Depending on your insurance company if they do not pay for adjustments that charge will be \$55.
- I, _____ have read and understand my responsibilities regarding financial payments to Horizon Surgical, P.C. I understand that payment is due at the time of visit, regardless of the outcome of my insurance filing.

Signature: _____

Date: _____

Witness: _____

Date: _____

RECENT HISTORY OF NONSURGICAL ATTEMPTS AT WEIGHT LOSS

NAME: _____

Which of the following have you tried within the last twelve months? (circle Y or N)
Please include month and year on the line below.

WEIGHT WATCHERS

Y N

PHYSICIAN SUPERVISED DIET

Y N

TOPS

Y N

OVEREATER'S ANONYMOUS

Y N

PRESCRIPTION DIET PILLS

Y N

PSYCHOTHERAPY

Y N

UNSUPERVISED DIETS (SLIMFAST, CALORIE COUNTING, ETC)

Y N

BEHAVIOR MODIFICATION

Y N

EXERCISE

Y N

OTHER (PLEASE SPECIFY)

Y N



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Last name, First, Middle	Date of Birth Sex	Marital Status M D S W
Street Address	Home Phone	Cell Phone
City State Zip code	Work Phone	FAX Number
Employer's Name	Email Address	
Employer's Street Address	Social Security Number	Drivers License # & State
City State Zip code	Occupation	
Emergency Contact: Relationship	Cell Phone	
Street Address, City, State, ZIP	Home Phone	Work Phone

Insurance Information:

Primary Insurance	Secondary Insurance
Address	Address
Customer Service Phone Number	Customer Service Phone Number
Policy or ID number	Policy or ID number
Subscribers Name	Subscribers Name
Relationship to Patient	Relationship to Patient
Subscriber's Employer, Address, Telephone Number	Subscriber's Employer, Address, Telephone Number

How did you hear about us? Physician Internet Newspaper/Magazine Other

Friend → Name: _____

I authorize release of medical information necessary to process claims for health insurance and disability benefits, and request that payment be made directly to my physician for services rendered. A copy of this authorization will be accepted to be as valid as the original.

Signature: _____ Date: _____

For Office Use Only:

Date of Physical: _____ Date of Surgery: _____ Auth #: _____



PATIENT HISTORY QUESTIONNAIRE

The information requested in this questionnaire is very important. To give you the best care, and to obtain your insurance approval we must have complete answers. Please be thorough. Blue or black ink only, please.

Name:		Date:	
Age:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Occupation: (If retired, what did you do?)	
Actual Body Weight	Your Measurement	Nurse Consult Measurement	Pre-Operative Measurement
Height			
Ideal Body Weight			
Excess Body Weight			
Target Weight			
Body Frame Small Medium Large		BMI:	BMI:
		Waist:	Waist:
		Hips:	Hips:

WEIGHT HISTORY

Please estimate as closely as possible for all that applies.

LIFE EVENT	AGE	WEIGHT
Birth weight		
Start of High School		
High School Graduation		
Marriage		
Lowest Weight in Past 5 Years		
Highest Weight in Past 5 Years		

In your own words, please describe what you hope to accomplish and how you believe your life will change by losing weight:



DIETARY HISTORY

Approximate age when you first seriously dieted: _____

List the diets and diet programs you have tried:

Program		Dates	Duration	MD Supervised?	Max Loss
Jenny Craig:	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____	_____
Nutri-Systems	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____	_____
Weight Watchers	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____	_____
OptiFast	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____	_____
Medi Fast	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____	_____
Fen/Phen/Redux	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____	_____
Meridia	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____	_____
Lindora	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____	_____
T.O.P.S.	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____	_____
O.A.	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____	_____
Acupuncture	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____	_____
Metabolife	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____	_____
Atkins Diet	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____	_____
Pritikin Diet	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____	_____

List any physician-supervised and documented weight loss attempt: _____

List any other diets and/or weight loss methods you've tried: _____

For female patients only:

Pregnancy #1	Year _____	Weight at start _____	at delivery _____
Pregnancy #2	Year _____	Weight at start _____	at delivery _____
Pregnancy #3	Year _____	Weight at start _____	at delivery _____
Pregnancy #4	Year _____	Weight at start _____	at delivery _____

FOOD PREFERENCES

Indicate which foods you prefer (which foods would most likely make you go off a diet).

Rank each selection from 1- like very much to 4- don't care.

- | | | |
|------------------------|--------------------|-----------------------|
| _____ Soda/Soft drinks | _____ French fries | _____ Chips/snacks |
| _____ Steaks/chops | _____ Candy | _____ Potatoes |
| _____ Chocolate | _____ Pasta | _____ Cookies |
| _____ Pizza | _____ Cakes/pies | _____ Salad dressings |
| _____ Fried foods | | |



WEIGHT RELATED ILLNESSES

Have you had, or do you have, any of the following illnesses or symptoms?

1. Heart Disease Yes No

If Yes: ♦Year Diagnosed _____

Do you have, or have you had:

- Angina
- M.I. (myocardial infarction, "heart attack")
- CABG (coronary artery bypass graft)
- Abnormal EKG
- Stress test to rule out cardiac problems
- Palpitations

2. High Cholesterol Yes No High Triglycerides Yes No

If Yes: ♦Year Diagnosed _____

♦List medications _____

3. High Blood Pressure Yes No

If Yes: ♦ Year Diagnosed _____

♦List medications _____

4. Diabetes Yes No

If Yes: ♦ Year Diagnosed: _____

- Gestational: Yes No
- Neuropathy: Yes No
- Controlled with: Diet

Oral Medication (list) _____

♦ Last fasting blood sugar: _____

5. Asthma Yes No

If Yes: ♦ Year Diagnosed: _____

♦ ER visits/last 2 yrs: _____

♦ Hospitalizations last 2 years: _____

♦ Steroids last 2 years: Yes No

6. Shortness of breath Yes No

If Yes: ♦ Can walk _____ blocks

♦ Stairs: _____ flights

7. Trouble Sleeping? Yes No

- ♦Morning headaches Yes No
- ♦Daytime drowsiness Yes No
- ♦ Restless sleep Yes No
- ♦Snoring Yes No
- ♦Awakenings at night Yes No
- ♦Observed apneas Yes No

Office Use: sleep study ordered _____ initials



8. Sleep Apnea Syndrome Yes No
 If Yes: ♦ Year Diagnosed: _____
 ♦ Last sleep study: _____ month/year
 ♦ CPAP used: Yes No

9. Heartburn/esophagitis/hiatus hernia? Yes No
 If Yes: ♦ Year Diagnosed: _____
 ♦ Upper GI series? Yes No
 ♦ Endoscopy? Yes No
 ♦ Medications: _____
 ♦ Frequency of use: _____

10. Belching up acid or sour fluid? Yes No

11. Coughing or choking at night? Yes No

Office Use: / UGI/endoscopy

12. Gallbladder disease? Yes No

If Yes: ♦ How was it Diagnosed? Ultrasound Physical Exam

13. Leakage of urine with laughing/coughing/sneezing? Yes No

If Yes: ♦ Wear pads frequently? Yes No

14. Low back strain/Pain/Sciatica? Yes No

If Yes: ♦ Seen by Chiropractor? Yes No

♦ Orthopedic Surgeon? Yes No

♦ Seen by Family Doctor? Yes No

♦ Medications taken: _____

15. Pain in Hips/Knees/Ankles/Feet? Yes No

If Yes: ♦ Seen by Chiropractor? Yes No

♦ Orthopedic Surgeon? Yes No

♦ Seen by Family Doctor? Yes No

♦ Medications taken: _____

16. Weight related injuries and trauma: _____

17. Venous Stasis Disease? Yes No

If Yes: ♦ Do you have Edema? Yes No

♦ Scaly & Thick Skin? Yes No

♦ Leg Ulcers? Yes No

18. Gout? Yes No

If Yes: ♦ Gouty Arthritis? Yes No

Using Medication? _____



20. Bra size (females only): _____
 Skin depressions from bra straps? Yes No
 Do you have shoulder pain? Yes No

PAST MEDICAL HISTORY

Please identify which of the following childhood illnesses you have experienced:

- Measles Mumps Chickenpox Obesity
 Rheumatic fever Heart murmur Asthma Tonsillectomy

Female Patients:

Number of pregnancies: _____ Age at first period: _____
 Number of live births: _____ Date of last period: _____
 Miscarriages/abortions: _____
 Obstetric complications: _____

Do you presently use:

Birth control pills Yes No List type: _____
 Estrogens Yes No List type: _____
 Other Contraceptive method: _____

Serious Illnesses:

Have you had:

- Hepatitis Blood Transfusion AIDS/HIV Exposure
 Colitis Kidney Disease Bleeding Abnormality
 Thyroid Problems _____

Please list below all serious illnesses and hospitalizations you have experienced in adulthood:

Major Illness	Date	Treatment

Major Surgery	Date

Allergies:

Allergic to any medications?: Yes No If Yes, please list medication and reaction:



Allergic to: **Surgical tape:** Yes No **Latex:** Yes No **Iodine:** Yes No
 Other Allergies:

Medications:

Please list below all medications you currently use:

Medication	Dose and Frequency

Do you use tobacco: Yes No Frequency: _____
 Are you willing to quit? Yes No
 Do you use alcohol: Yes No Frequency: _____

FAMILY HISTORY

Family Member	Living?	Age	If Deceased, age	Illness/Cause of death
Mother				
Father				
Maternal Grandmother				
Maternal Grandfather				
Fraternal Grandmother				
Fraternal Grandfather				
Sibling:				
Sibling:				
Sibling:				
Sibling:				

Please indicate if there is a family history of:

- Obesity
- Diabetes
- High Blood Pressure
- Heart Disease
- High Blood Cholesterol
- Lung disease, Asthma or Emphysema
- Kidney Disease
- Bleeding tendency or Blood Disorder
- Breast Cancer
- Colon Cancer



SYSTEM REVIEW

Please circle all symptoms you currently experience, or have experienced in the past Feel free to add any additional problems or information.

1. HEAD, EYE, EAR, NOSE & THROAT: stuffy Nose - runny Nose - hay fever - sinus trouble - earache - headache - blurry vision - double vision - haloes around lights - loss of night vision - buzzing in ears - ringing in ears - discharge from ear - loss of hearing - dizziness - vertigo - loss of balance - sore throat - lump in throat - trouble swallowing - pain with swallowing - hoarseness

2. RESPIRATORY: cough - wheezing - shortness of breath at night - use of two pillows - blood in sputum - out of breath with exertion - wake up at night short of breath - wake up at night coughing or choking - asthma - emphysema - bronchitis

3. CARDIOVASCULAR: palpitations - pounding heart - skipping heartbeat - pains in chest - pains in neck - pains in arms - squeezing of chest - heart attack - heart murmur - abnormal electrocardiogram - irregular heartbeat - high blood pressure - pain in legs - cold feet - blue toes - blue finger-loss of pulses

4. GASTROINTESTINAL: heartburn - nausea - vomiting - belching fluid in throat - burning in throat - food sticking in chest - pains in stomach - burning in stomach - acid stomach - diarrhea - constipation - pain with bowel movement - blood in stools - hemorrhoids - fissures - cramps - gassiness - irritable colon - colitis

5. GENITOURINARY: pain with urination - trouble starting urine - trouble stopping urine - small urine stream - blood in urine - kidney stones - bladder stones - kidney failure - nephritis - urinary tract infections - frequent urination - getting up at night to urinate - leakage of urine with cough or sneeze

- Men: discharge from penis - loss of erection - painful erection
- Women: vaginal discharge - vaginal bleeding - pain with intercourse - irregular periods

6. ENDOCRINE (GLANDULAR): low thyroid - hyperthyroid - goiter - Grave's Disease - thyroid Nodules - xray to thyroid - diabetes - adrenal gland tumor - frequent flushing - frequent heavy sweating

7. MUSCULOSKELETAL: pain in joints - swelling of joints - redness of skin over joints - warm joints - fluid in joints - arthritis - broken bones - sprains - low back pain - hip pain - knee pain - ankle pain - foot pain - flat feet - slipped disk - herniated disk - sciatica

8. NEUROLOGICAL: dizziness - vertigo - falling to the side - falling at night - numbness - tingling - pins and needles feelings - weakness of any muscles - twitching of muscles - weakness of grip — shakiness — tremors — fainting — convulsions - fits — loss of consciousness

9. PSYCHOLOGICAL: nervousness - anxiety - depression - thoughts of suicide - suicide attempts - hospitalization for emotional problems - psychiatric treatment - psychological counseling



Personal Physicians:

Please list all the physicians under whom you receive medical care:

	Name	Address/Location	Telephone
Primary Care Physician	_____	_____	_____
Internist	_____	_____	_____
Gynecologist	_____	_____	_____
Orthopedist	_____	_____	_____
Psychiatrist	_____	_____	_____
Psychologist	_____	_____	_____
Therapist	_____	_____	_____
Other (Specify)	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

