Great Plains Bariatric Center
"The Journey to a New, Healthier You"

Dr. Roy Greeway M.D.

PATIENT INFORMATION SHEET

PATIENT NAME: _____ SSN#_____

DATE OF BIRTH: _____ AGE:_____ SEX: M F MARITAL STATUS: M S D W

ADDRESS: _____

CITY: _____STATE:_____ZIP:_____

HOME:_____CELL:_____WK:_____

EMAIL: _____PLACE OF EMPLOYMENT:_____

RACE: _____ PREFERRED LANGUAGE: _____

EMERGENCY CONTACT:_____**PHONE**:_____

RELATIONSHIP**:**_____

REFERRING PHYSICIAN OR CURRENT PRIMARY CARE PROVIDER:

NAME:_____PHONE:_____FAX:_____

CITY:_____STATE:_____ZIP:_____

MAY WE CONTACT YOUR PRIMARY CARE PROVIDER AND/OR REFERRING PHYSICIAN? YES NO

EMPLOYER INFORMATION:

NAME OF COMPANY_____PHONE:_____

ADDRESS:_____FAX:_____

POSITION:_____DATES EMPLOYEED:_____

INSURANCE INFORMATION:

PRIMARY INSURANCE COMPANY:_____

ID#:_____GROUP#:_____

SUBSCRIBER'S NAME:_____SUBSCRIBER'S SS#_____

SUBSCRIBER'S DATE OF BIRTH:_____SUBSCRIBER'S SEX: M F

SUBSCRIBER'S PLACE OF EMPLOYMENT:_____

SUBSCRIBERS RELATIONSHIP TO PATIENT:_____

ADDRESS:_____CITY_____STATE_____ZIP____

SECONDARY INSURANCE COMPANY:_____

ID#:_____GROUP#:_____

SUBSCRIBER'S NAME:_____SUBSCRIBER'S SS#_____

SUBSCRIBER'S DATE OF BIRTH:_____SUBSCRIBER'S SEX: M F

SUBSCRIBER'S PLACE OF EMPLOYMENT:_____

SUBSCRIBERS RELATIONSHIP TO PATIENT:_____

ADDRESS:_____CITY_____STATE_____ZIP____

INSURANCE IS NOT A GUARANTEED PAYMENT. UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE THROUGH OUR OFFICE, BALANCE IS DUE WITHIN 90 DAYS OF THE INSURANCE CLAIM.

"THE INFORMATION STATED ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE. I, THE PERSON RESPONSIBLE FOR PAYMENT OF MEDICAL CARE FOR THE ABOVE PATIENT, AGREE TO PAY FOR THE OFFICE VISIT AND SERVICES THE DAY THE CARE IS PROVIDED. I AGREE TO PAY ANY BALANCE DUE ON OTHER CHARGES WITHIN 90 DAYS FROM THE DATE THAT SERVICE IS PROVIDED".

SIGNATURE:_____**DATE:**_____

Name: _____Date of Birth_____ Date_____

Signers printed name if different from patient:_____

I authorize GPRMC to release my protected health information to the following individuals (if any):

NAME:_____RELATIONSHIP:_____

NAME:_____RELATIONSHIP:_____

NAME:_____RELATIONSHIP:_____

Financial Policy

We accept cash, checks, Visa, MasterCard, Discover and American Express.

Insurance Coverage: The balance on your account is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. If your insurance company has not paid your account in full within 90 days from the date services are rendered, the balance will automatically be transferred to your responsibility. Please be aware that some, and perhaps all, of the services provided by the physician or other licensed professional may be non-covered services and not considered reasonable and necessary under your medical insurance. You must inform us if your insurance or your Primary Care Provider changes. If you fail to notify us about any changes, you will be responsible for all charges incurred.

No Insurance Coverage: If you do not have insurance coverage, you are expected to pay to your account in full before any medical procedures are performed. We accept cash, checks, Visa, MasterCard, or American Express. If you are unable to pay your account in full at the time services are rendered, we will accept a payment schedule as follows: 50% in advance, 25% due in 30 days from the date of the procedure, and the remaining balance due in the next 60 days. (If your bill is $100.00 or less, then the balance is due in full.)

I, _____, have read the above information and agree to the financial policy. I hereby authorize payment directly to GPRMC/Southwest General Surgery. I understand that co-pays are due at the time services are rendered. I confirm that the above information is true and accurate to the best of my knowledge.
Please print your name on the line above and sign below

Signature: _____Date:_____

Signers printed name if different from patient:_____

Notice of Privacy Practices:

I hereby acknowledge that I have received the Notice of Privacy Practices from my provider at GPRMC

Signature:_____**Date**:_____

Release of Medical Information:

This will serve as authorization to release all medical records contained in the medical chart that relates to any physical condition or treatment given by any physician employed by GPRMC to the above named patient. This will also serve as authorization for release of information to referring physicians and the patient's insurance company for insurance claim purposes only.

The information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such hepatitis, syphilis, gonorrhea and the human immunodeficiency virus also known as Acquired Immune Deficiency Syndrome (AIDS). Oklahoma Statute: 63 OS 1.502.2

I also authorize you to accept a photo copy of this release and it shall have the same force and effect as if it were the original. I acknowledge that I understand all of the above information. My signature indicates that I have read this Medical Release and grant the request for Authorization.

Signature: _____Date:_____

Medicare Patients Only:

I hereby authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a payment of medical insurance benefits either to myself or the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my medical treatment.

Signature: _____Date:_____

Name: _____Date of Birth_____ Date_____

YOUR DOCTORS:
PLEASE PROVIDE INFORMATION ON YOUR PRIMARY HEALTH CARE PROVIDERS DURING THE LAST 5 YEARS. PLEASE ALSO INCLUDE CURRENT SPECIALISTS FOR EXAMPLE: CARDIOLOGIST, PULMONOLOGIST, HEMATOLOGIST, ENDOCRINOLOGIST, SLEEP MEDICINE, ORTHOPEDIC SURGEON, ETC). USE THE REVERSE SIDE IF MORE SPACE IS NEEDED

1. PHYSICIAN NAME:_____SPECIALITY:_____
   ADDRESS:_____PHONE:_____
   CITY/STATE/ZIP:_____FAX:_____
   DATES OF TREATMENT:_____
   APPROX WEIGHT AT LAST VISIT_____
   DO WE HAVE YOUR PERMISSION TO CONTACT THIS PHYSICIAN? CIRCLE ONE YES NO

2. PHYSICIAN NAME:_____SPECIALITY:_____
   ADDRESS:_____PHONE:_____
   CITY/STATE/ZIP:_____FAX:_____
   DATES OF TREATMENT:_____
   APPROX WEIGHT AT LAST VISIT_____
   DO WE HAVE YOUR PERMISSION TO CONTACT THIS PHYSICIAN? CIRCLE ONE YES NO

3. PHYSICIAN NAME:_____SPECIALITY:_____
   ADDRESS:_____PHONE:_____
   CITY/STATE/ZIP:_____FAX:_____
   DATES OF TREATMENT:_____
   APPROX WEIGHT AT LAST VISIT_____
   DO WE HAVE YOUR PERMISSION TO CONTACT THIS PHYSICIAN? CIRCLE ONE YES NO

4. PHYSICIAN NAME:_____SPECIALITY:_____
   ADDRESS:_____PHONE:_____
   CITY/STATE/ZIP:_____FAX:_____
   DATES OF TREATMENT:_____
   APPROX WEIGHT AT LAST VISIT_____
   DO WE HAVE YOUR PERMISSION TO CONTACT THIS PHYSICIAN? CIRCLE ONE YES NO

5. PHYSICIAN NAME:_____SPECIALITY:_____
   ADDRESS:_____PHONE:_____
   CITY/STATE/ZIP:_____FAX:_____
   DATES OF TREATMENT:_____
   APPROX WEIGHT AT LAST VISIT_____
   DO WE HAVE YOUR PERMISSION TO CONTACT THIS PHYSICIAN? CIRCLE ONE YES NO

Name: _____Date of Birth_____ Date_____

6. PHYSICIAN NAME:_____SPECIALITY:_____
   ADDRESS:_____PHONE:_____
   CITY/STATE/ZIP:_____FAX:_____
   DATES OF TREATMENT:_____
   APPROX WEIGHT AT LAST VISIT_____
   DO WE HAVE YOUR PERMISSION TO CONTACT THIS PHYSICIAN? CIRCLE ONE YES NO

7. PHYSICIAN NAME:_____SPECIALITY:_____
   ADDRESS:_____PHONE:_____
   CITY/STATE/ZIP:_____FAX:_____
   DATES OF TREATMENT:_____
   APPROX WEIGHT AT LAST VISIT_____
   DO WE HAVE YOUR PERMISSION TO CONTACT THIS PHYSICIAN? CIRCLE ONE YES NO

8. PHYSICIAN NAME:_____SPECIALITY:_____
   ADDRESS:_____PHONE:_____
   CITY/STATE/ZIP:_____FAX:_____
   DATES OF TREATMENT:_____
   APPROX WEIGHT AT LAST VISIT_____
   DO WE HAVE YOUR PERMISSION TO CONTACT THIS PHYSICIAN? CIRCLE ONE YES NO

9. PHYSICIAN NAME:_____SPECIALITY:_____
   ADDRESS:_____PHONE:_____
   CITY/STATE/ZIP:_____FAX:_____
   DATES OF TREATMENT:_____
   APPROX WEIGHT AT LAST VISIT_____
   DO WE HAVE YOUR PERMISSION TO CONTACT THIS PHYSICIAN? CIRCLE ONE YES NO

10. PHYSICIAN NAME:_____SPECIALITY:_____
    ADDRESS:_____PHONE:_____
    CITY/STATE/ZIP:_____FAX:_____
    DATES OF TREATMENT:_____
    APPROX WEIGHT AT LAST VISIT_____
    DO WE HAVE YOUR PERMISSION TO CONTACT THIS PHYSICIAN? CIRCLE ONE YES NO

Name: _____Date of Birth_____ Date_____

Past Medical History

Y N High Blood Pressure (Hypertension)
Y N Coronary Heart/Artery Disease
Y N Atrial Fibrillation
Y N Myocardial Infarction/Heart Attack (MI)
Y N Valvular Heart Disease/Problems with Heart Valves
Y N Hyperlipidemia/High Cholesterol
Y N Peripheral Vascular/Arterial Disease (PVD)
Y N DVT/Blood Clot

Y N Asthma
Y N COPD/Emphysema
Y N Tuberculosis

Y N CVA/Stroke/Mini-stroke
Y N Cerebrovascular/Carotid Artery Disease

Y N Diabetes – Type 1
Y N Diabetes – Type 2

Y N GERD/Heartburn
Y N Peptic Ulcer Disease/Stomach Ulcers (PUD)
Y N Hepatitis B
Y N Hepatitis C
Y N Cirrhosis
Y N GI Bleed
Y N Colon Cancer
Y N Crohn's Disease

Y N Anxiety
Y N Depression
Y N Hypothyroidism
Y N Hyperthyroidism

Y N Chronic Renal/Kidney Failure (CRF)
Y N Osteoporosis
Y N Osteoarthritis/Arthritis
Y N Rheumatoid Arthritis

Y N Brain Tumor
Y N Seizure Disorder

Y N Breast Cancer
Y N Breast Disease (other than cancer)
Y N Abnormal Pap Smear

Name: _____Date of Birth_____ Date_____

Y N Cervical Cancer

Please List other chronic or past medical problems not mentioned above: (for example, sleep apnea, bleeding disorders, cancers, hospitalizations, etc.)

MEDICATIONS

Include all prescribed and all over the counter medicines/vitamins/"Natural remedies" etc.

Name of Medication	Strength	Schedule	Reason and are you taking as ordered? Y or N

ALLERGIES: If no drug allergies, please circle NKDA

Name of Medication	Reaction	Name of Medication	Reaction

PLEASE DOUBLE CHECK for ACCURACY

Name: _____Date of Birth_____ Date_____

Pharmacy:_____Phone:_____
Address/Intersection:_____

Name: _____Date of Birth_____ Date_____

Past Surgical History

Have you had:			Year
Appendectomy/Appendix	Y	N	
Cholecystectomy/Gallbladder/Gallstones	Y	N	
Colectomy/Colon Resection	Y	N	
Small Intestine Resection	Y	N	
Hiatal Hernia/Fundoplication/Stomach Wrap	Y	N	
Partial Gastrectomy/Ulcer surgery	Y	N	
Liver Resection	Y	N	
Splenectomy/Spleen Removal	Y	N	
Pancreas Surgery	Y	N	
Ventral Hernia Repair/Umbilical Hernia Repair	Y	N	
Inguinal Hernia Repair	Y	N	
C-Section	Y	N	
Hysterectomy/Uterus (other than ablation)/Ovaries	Y	N	
Tubal Ligation or Endometriosis Surgery	Y	N	
Mastectomy/Lumpectomy/Breast Surgery	Y	N	
Prostate Surgery	Y	N	
Heart Bypass or Valve Surgery	Y	N	
Lung Surgery	Y	N	
Tracheostomy	Y	N	
Neck or Back Surgery	Y	N	
Thyroidectomy/Thyroid removal/Parathyroid Surgery	Y	N	
Dialysis Access Surgery/Surgeries	Y	N	

Other Types of Surgery	Year

Name: _____Date of Birth_____ Date_____

Social History

	Circle One	
Do you smoke?	Y	N

If Yes:

Cigarettes?	Y	N	How Many Packs per day? _____
Cigars?	Y	N	How Many Cigars per week? _____
Pipes?	Y	N	How Many Pipes per week? _____
For how many years?		_____	

If No:

Do you Vape or use an e-cig?	Y	N
Did you smoke previously?	Y	N
If Yes, when did you quit?	_____	

Do you use smokeless tobacco?	Y	N
Do you Drink Alcohol?	Y	N
If yes, how many drinks per day?	_____	
Do you use illicit Drugs?	Y	N
If yes, please list:	_____	
	_____	
	_____	

Any nicotine that gets into your body will slow and alter healing after any surgery. Please know that before performing any weight loss surgical procedures, we require that you not use nicotine in any form and we will test your urine for nicotine periodically as you move through our program. If your nicotine screen is positive, your surgery will be canceled. This policy is for your safety and well-being.

Name: _____Date of Birth_____ Date_____

Family History

Please indicate Y or N and the family member(s) affected

Heart Attack/Coronary Artery Disease	Y	N	
Congestive Heart Failure	Y	N	
High Blood Pressure	Y	N	
Stroke/Mini-stroke	Y	N	
Bleeding Disorders	Y	N	
Diabetes	Y	N	
Asthma	Y	N	
COPD	Y	N	
Sleep Apnea	Y	N	
High Cholesterol	Y	N	
Breast Cancer	Y	N	
Colon Cancer	Y	N	
Hepatitis	Y	N	
Kidney Disease	Y	N	
Crohn's Disease or Ulcerative Colitis	Y	N	
Seizure Disorder	Y	N	
Abnormal Reaction to Anesthesia	Y	N	
Others:			
_____	Y	N	_____
_____	Y	N	_____
_____	Y	N	_____

OB/GYN History

Are You in Menopause? Y N

If No:

Date Last Period Began _____

In your life, how many:

times have you been Pregnant _____

times have you had a Miscarriage _____

times have you had an Abortion _____

Living Children do you have _____

Name: _____Date of Birth_____ Date_____

Review of Systems (1 of 3)

General

Y	N	Fever
Y	N	Anorexia
Y	N	Weight Loss

Gastro-Intestinal

Y	N	Abdominal Pain
Y	N	Nausea
Y	N	Vomiting
Y	N	Diarrhea
Y	N	Constipation
Y	N	Changes in Bowel Habits
Y	N	Melena (Dark bloody stools)
Y	N	Hematochezia (Bright red blood in stools)
Y	N	Jaundice
Y	N	Gas/Bloating
Y	N	Indigestion/Heartburn
Y	N	Dysphagia
Y	N	Odynophagia

Breast (Male and Female)

Y	N	Left Breast Lump
Y	N	Right Breast Lump
Y	N	Nipple Discharge
Y	N	Bloody Nipple Discharge
Y	N	Breast Pain
Y	N	Abnormal Mammogram
Y	N	Breast Enlargement

Cardio-Vascular

Y	N	Chest Pain
Y	N	Palpitations
Y	N	Syncope
Y	N	Peripheral Edema

Respiratory

Y	N	Cough
Y	N	Shortness of Breath
Y	N	Hemoptysis (Coughing up blood)
Y	N	Wheezing
Y	N	Pleuritic Chest Pain (pain w deep breathing)

Name: _____Date of Birth_____ Date_____

Review of Systems (2 of 3)

Vascular

Y	N	Varicose Veins
Y	N	Leg Swelling
Y	N	Leg Redness
Y	N	Leg Coolness
Y	N	Pain in legs when walking
Y	N	Pain in legs when resting
Y	N	Pain in legs at night
Y	N	Blue Toes

Genito-Urinary (Female)

Y	N	Vaginal Discharge
Y	N	Incontinence (cannot control urine)
Y	N	Dysuria (pain/burning w urination)
Y	N	Hematuria (bloody urine)
Y	N	Urinary Frequency
Y	N	Abnormal Vaginal Bleeding
Y	N	Pelvic Pain
Y	N	Are you currently Pregnant

Genito-Urinary (Male)

Y	N	Dysuria (pain/burning w urination)
Y	N	Hematuria (bloody urine)
Y	N	Penile Discharge
Y	N	Urinary Frequency
Y	N	Urinary Hesitancy
Y	N	Nocturia (urinating at night)
Y	N	Incontinence (cannot control urine)
Y	N	Erectile Dysfunction

Wound

Y	N	Wound Redness
Y	N	Wound Discharge
Y	N	Wound Pain
Y	N	Opening of Wound
Y	N	Purulent drainage from wound (puss)
Y	N	Bleeding from wound

Dermatologic

Y	N	Suspicious skin lesion/mole
Y	N	New skin lesion/mole

Name: _____Date of Birth_____ Date_____

Y	N	Changing skin lesion/mole
Y	N	Rash
Y	N	Itching
Y	N	History of Skin Cancer

Review of Systems (3 of 3)

Neurologic

Y	N	Paralysis
Y	N	Paresthesia (numbness)
Y	N	Seizures
Y	N	Frequent Headaches

Psychiatric

Y	N	Depression
Y	N	Anxiety
Y	N	Memory Loss
Y	N	Suicide Ideation/Thoughts
Y	N	Hallucinations
Y	N	Paranoia
Y	N	Phobias
Y	N	Confusion

Endocrine

Y	N	Cold Intolerance
Y	N	Heat Intolerance
Y	N	Polydipsia
Y	N	Polyphagia
Y	N	Polyuria
Y	N	Unusual Weight Change

Hematologic

Y	N	Abnormal Bruising
Y	N	Bleeding
Y	N	Enlarged Lymph Nodes

Musculo-skeletal

Y	N	Back Pain
Y	N	Sciatica
Y	N	Arthritis

Name: _____Date of Birth_____ Date_____

Great Plains Bariatric Center
"The Journey to a New, Healthier You"

Dr. Roy Greeway M.D.

Bariatric Surgery Questionnaire

Have **YOU** had previous weight loss or bariatric **SURGERY**? CIRCLE ONE YES NO
If no, continue to "Other Weight Loss Attempts" section below.
If yes, complete all sections below:

Date of Previous Weight Loss Surgery:_____

Surgeon:_____

City/State/Phone:_____

Type of Procedure:

Gastric Bypass (Roux-en-Y), Laparoscopic	Gastric Bypass (Roux-en-Y),	Open Gastric Band, adjustable
Sleeve Gastrectomy, Laparoscopic	Sleeve Gastrectomy, Open	Gastric Band, non-adjustable
Bilio-pancreatic Diversion	Duodenal Switch	Vertical Banded Gastroplasty

Other _____

Original Weight:_____ **Lowest Weight Achieved:**_____ **Current Weight**:_____

OTHER WEIGHT LOSS ATTEMPTS

	PROGRAM	PROGRAM DATES	WEIGHT LOSS	WEIGHT REGAINED	HOW LONG TO REGAIN	PHYSICIAN SUPERVISED? Y/N	DIETICIAN SUPERVISED? Y/N
1	Weight Watchers						
2	Jenny Craig						
3	Medifast/Optifast						
4	Nutri-System						
5	High Protein. Low Carb (Atkins, Southbeach)						
6	Herbalife						
7	Over the Counter Diet Pills						
8	SlimFast or similar						
9	Phentermine (Adipex, Fastin, Etc)						
10	Fenfluramine/Phentermine (Fen/Phen)						
11	Meridia or Xenical						
12	Hypnosis, Jaw wiring, Acupuncture						
13	Others						

Name: _____Date of Birth_____ Date_____

Type of Exercise	**Times per week**	**Duration each time**
Walking		
Jogging		
Water Aerobics		
Yoga		
Zumba		
Weights/Personal Trainer		
Running/Treadmill		
Elliptical		
Stationary bicycle		
Outdoor cycling		
Other Please Specify:		

Do you have or have you seen a Dietitian? **Yes** **No**
Name:_____ Phone:_____
Address:_____City/State/Zip:_____
May we contact the dietitian? Yes No
If you do not have a dietitian or do not want us to contact your Dietitian, we will get you to see our Dietitian

Do you have or have you seen a Psychologist/Psychiatrist? **Yes** **No**
Name:_____Phone:_____
Address:_____City/State/Zip:_____
May we contact this provider? Yes No
If you do not have a Psychologist or Psychiatrist (or do not want us to contact them), we will get to see our Psychologist

Dietary Habits:
Do you keep a food journal? Yes No
How many calories do you normally consume in a day? _____
How many meals do you eat on an average day? _____
How many times do you snack on an average day? _____
How many times a week do you eat out? _____
How long have you been overweight? _____
Do you binge eat? Yes No Why/When? _____
Have you ever used vomiting as a means of weight control? _____
Have you ever used laxatives or diuretics as a means of weight control? _____
Do you use sleeping pills? Yes No Average hours of sleep each night? _____

Support System:
Who do you live with? _____
Who prepares the meals in your house? _____
Does your family and those around you support your desire for weight loss surgery? _____

Have you been involved with any online or in-person weight loss support groups? _____
Which ones? _____
Family history of obesity? _____

Nutritional History:
Food Allergies/Intolerances: _____
Cultural Food restrictions: _____
Food Cravings: _____
Vitamins/Nutritional Supplements: _____
Do you drink alcohol? Yes No How much? _____

On average, how many servings of the following foods/drinks do you consume daily?

Food Type	Daily Amount	Drink Type	Daily Amount
Meat		Water	
Beans		Zero Calorie Drink	
Vegetables		Regular Soda	
Fruits		Diet Soda	
Cheese		Regular Tea	
Yogurt		Decaf Tea	
Nuts		Sweetened Tea	
Bread, Pasta, Rice		Sweetened Decaf Tea	
Fats/Oils		Regular Coffee	
Sweets/Candy		Decaf Coffee	
Salty Snacks/Chips		Creamer	
Fried Foods		Sugar Packets	
		Fruit Juice	
		Energy Drink	

Explain your motivation to have weight loss surgery:

_____
_____
_____
_____
_____

Explain your expectations following weight loss surgery:

_____
_____
_____
_____
_____

What if any life style changes have you already made in preparation for weight loss surgery?

_____
_____
_____
_____
_____

Name: _____Date of Birth_____ Date_____

STOP-BANG Sleep Apnea Screening

STOP		
Do you **S**nore loudly (louder than talking or loud enough to be heard through closed doors)?	YES	NO
Do you often feel **T**ired, fatigued, or sleepy during the daytime?	YES	NO
Has anyone **O**bserved you stop breathing during sleep?	YES	NO
Do you have or are you being treated for high blood **P**ressure?	YES	NO

BANG		
BMI greater than 35kg/m2?	YES	NO
Age over 50 years old?	YES	NO
Neck circumference over 16 inches (40cm)?	YES	NO
Gender: Male?	YES	NO

TOTAL SCORE (add the yes's)		

Total Score 5-8 = High risk of Obstructive Sleep Apnea (OSA)

Total Score 3-4 = Intermediate risk of OSA

Total Score of 0-2 = Low risk of OSA

Name: _____Date of Birth_____ Date_____

Notice to our patients:

We are honored that you have considered us for your weight loss needs. We have put a great deal of effort into developing a program that will be successful. We are dedicated to getting you through our program safely and improving your overall health in the process. Unfortunately, this involves work on the part of several people whose services are not covered by insurance of any type. To help offset the costs we incur to get you through our program, we charge a one-time, upfront fee of $250 that is not billable to your insurance. Once you have been determined to be a candidate for our program, we will charge you this fee. This fee is non-refundable if you fail to complete our program for any reason. If, after the initial visit with your surgeon, it is determined you are not appropriate for our program, standard office visit charges will apply.

Please initial that you have read and accept this policy _____

HOW DID YOU HEAR ABOUT US:

TV NEWSPAPER BILLBOARD INTERNET

FRIEND OR FAMILY**:**_____

OTHER:_____

We Welcome and Value Your Feed Back!

It would mean a lot to us if you would tell us what we are doing well and how we could improve. We are happy to receive feedback in person and we encourage you to evaluate us on one of the many online physician rating websites. Please look for your surgeon (Roy M Greenway Jr) on:

www.healthgrades.com
www.vitals.com
www.ucomparehealthcare.com
www.ratemds.com

Name: _____Date of Birth_____ Date_____