Weight and Wellness Center
SWL Program Application

Signature Healthcare
110 Liberty St.
Brockton, MA 02301
Phone: 855-609-9355
Fax: 508-565-0097
www.MySignatureCare.org/Weightloss

Date________________________

Last Name: _________________First Name: ________________ Sex____ Date of birth ____/____/____

Address ____
street city state zip code

Telephone: Home _________________ Work _________________Cell: ___________________ Daytime is home/work/cell number (circle)

E-mail address __________________________________ Fax (____)______________

Marital status: _____ Number of children _____

Occupation: ____

Place of employment: ____

Current weight: _______________ Current height: ___________

How did you hear about our program? ___My Physician ____ A Former patient ____Internet: Which site? ______________________________
___Advertisement ____Other

Insurance Information (FILL OUT COMPLETELY)

Insurer Name and State: (Blue Cross/Blue Shield – Ohio) ____

Insurance ID # ____

Insurance Company Address: ____

Named of Subscriber: ____

Relationship to patient: _____ self _____ spouse _____ child _____ other

I have carefully read all the materials in this Assessment and have answered the questions as truthfully as possible.

____ ____

Health Care Providers – Medical (THIS INFORMATION IS REQUIRED – FILL OUT COMPLETELY)

- Primary Care Physician ____

Address____

Telephone (____) ___________________ Fax (____) ____________________

Other Health Care Providers – Mental Health (THIS INFORMATION IS REQUIRED – FILL OUT COMPLETELY)

- Therapist or Mental Health Counselor ______________________________________

Address ____

Telephone (____) ___________________ Fax (____) ____________________

- Psychopharmacologist ______________________________________

Address ____

Telephone (______) ___________________ Fax (____) ____________________

Please list all other medical specialists and healthcare providers. If you need more space, list additional providers' names, specialties, addresses, and telephone and fax numbers on the back of this page.

Office Use only

MR#: ________________________

1st Appt: ________________________

Provider: ________________________

• **Provider Name**____ Specialty________________

Address ____

Telephone (____) __________________ Fax (____) __________________

• **Provider Name**____ Specialty________________

Address ____

Telephone (____) __________________ Fax (____) __________________

• **Pharmacy name** ____

Pharmacy address ____

Telephone (____) ____________________________ Fax (____) ____________________________

Alcohol, Tobacco, and Non Prescription Drug History

Current and Past Use: List all alcohol, tobacco, and nonprescription drugs that you currently and previously used and the amounts that were used.

	Type	Amount Per Day	How often did you use this substance per day/week?	How long did you use this substance?	When did you stop using this substance?
Alcohol					
Tobacco					
Drugs					

Family History

• **People currently living in your household**

Name	Age	Relationship

Please check any of the following conditions that your parents, your siblings, or your children have been diagnosed with.

Check:	Condition:	Comments:
	Obesity	
	Diabetes	
	Heart Disease	
	High Cholesterol	
	Cancer - type (s)	

Hospitalizations

Please list all inpatient hospitalizations (including psychiatric and substance abuse treatment). If you need additional room, please continue on the back of this page.

Approximate Date	Problem	Hospital
______	______	______
______	______	______
______	______	______
______	______	______

Medical History

Please check each of the following conditions that you have, are experiencing now, or have experienced in the past.

- Heart and Circulation — Comments

_______ Chest pain/coronary artery disease/angina _______

_______ Congestive heart failure _______

_______ Irregular or rapid heart beat (arrhythmias) _______

_______ Peripheral vascular disease _______

_______ Leg swelling (edema) _______

_______ Hypertension/high blood pressure _______

_______ Stroke _______

_______ Blood clots _______

_______ Others: _______ _______

- Lungs — Comments

_______ Shortness of breath _______

___at rest ___walking on flat ground ___on stairs/hills _______

_______ Asthma _______

_______ COPD (emphysema, chronic bronchitis) _______

_______ Pulmonary embolism (blood clot in the lungs) _______

_______ Sleep apnea _____C-PAP settings _________ _______

_______ Other: _______ _______

- Endocrine — Comments:

_______ Diabetes _______

_______ High cholesterol, high triglycerides _______

_______ Infertility _______

_______ Menstrual irregularities _______

_______ Thyroid _____Hypothyroidism (underactive) _______

_____Hyperthyroidism (overactive) _______

_______ Excessive hot or cold feeling _______

_______ Visual changes _______

_______ Change in voice _______

____

_______ Recent increase in thirst or urination _______

_______ Abnormal hair growth _______

_______ Abnormal menstrual periods _______

_______ Numbness or tingling in hands or feet _______

_______ Other: _______ _______

• Gastrointestinal/GI Comments

_______ Gastroesophageal Reflux (GERD) _______

_______ Heartburn _______

_______ Ulcers _______

_______ Crohn's Disease, Ulcerative Colitis _______

_______ Frequent diarrhea _______

_______ Frequent constipation _______

_______ Gallbladder ____gallstones ____gallbladder removed _______

_______ Fatty liver _______

_______ Colon ____hemorrhoids ____ polyps _______

_______ Liver ____hepatitis ____ cirrhosis _______

_______ Other: _______ _______

• Blood Comments

_______ Anemia _______

_______ Iron deficiency _______

_______ Would accept a blood transfusion if it was medically necessary? Yes No _______

_______ Other: _______

• Musculoskeletal Comments

_______ Back pain _______

_______ Arthritis type: _______ _______

_______ Other: _______ _______

• Psychiatric Comments

_______ Depression _______

_______ Bipolar disorder _______

_______ Eating disorder _____anorexia _____bulimia _______

_______ Other: _______ _______

• Other Comments

_______ Kidney disease _______

_______ Kidney stones _______

_______ Other: _______ _______

_______ Other: _______ _______

Weight and Weight Loss History – THIS INFORMATION IS REQUIRED – FILL OUT COMPLETELY

Weight 1 year ago : ______________ Estimated daily caloric intake: __________________

Are you currently at your highest weight ever? Yes __________ No _________

If you answered 'no', what was you highest weight? _____ lbs. When? __________

Please fill in all previous weight loss methods that you have tried. List any additional methods.

Dietary Intervention	# Wks/Months Attempted	Pounds Lost	Length of Time Sustained Wt Loss
Weight Watchers			
Jenny Craig			
Nutrisystem			
Diet Center			
Diet Workshop			
LA Weight Loss			
TOPS			
Atkins			
South Beach Diet			
OA			
HMR			
Optifast			
Medifast			
Phentermine (Fastin, Adipex)			
Redux (Dexfenfluramine)			
Pondimin (fenfluramine)			
Fen-Phen			
Meridia (Sibutramine)			
Xenical (Orlistat)			
Dexetrim			
Metabolife			
Trimspa			
Ephedra (Ma Huang)			
Slimfast			
Hypnosis			
Acupuncture			
Nutritionist			
Behavioral Therapy			
Other:			

At each age below, circle the best description of how heavy you were in comparison to your peers.

Age 5: obese heavy average below average / **Age 10:** obese heavy average below average

Age 15: obese heavy average below average /. **Age 20:** obese heavy average below average

When have you noticed putting on the most weight? ____

____

____

What methods have you discovered helped you lose weight? ____

____

____

Does your family support your weight loss efforts? Yes No ____

____

____

Please indicate your level of motivation to lose weight using the scale below:

0 1 2 3 4 5 6 7 8 9 10

Unmotivated Neutral/Unsure Motivated

How much weight do you expect to lose as a result of treatment?

___Less than 50 lbs. ___50-100 lbs. ___100-150 lbs. ___more than 150 lbs.

Habits and Preferences – THIS INFORMATION IS REQUIRED – FILL OUT COMPLETELY

Do you eat 3 meals per day? Yes No

If not, what meals do you tend to skip? ____________________

Eating habits: Binge Eater Stress Boredom Sadness Loneliness Anger Other: __________

Please list the other foods you snack on: ____________________

____

Do you suffer from uncontrollable cravings, or do you feel out of control around certain foods? Yes No

If yes, please explain & identify foods you typically crave: ____________________

____

Do any of these apply to you? Check all that apply

	Eating large portions		Skipping breakfast
	Eating too much sugar		No exercise
	Eating too many fatty foods		Don't drink enough water
	Use too much salt		Eat when not really hungry
	Eat too fast – not mindful		Eat a lot of fast food
	Lots of junk food		Eat little or no fruit
	Little or no vegetable		Skip meals often

In your household, who plans meals? ____________________

Who does the cooking? ____________________

Who does the grocery shopping? ____________________

How frequently do you eat meals away from the home (at restaurants)?

Everyday 5x/week 3-4x/week 1-2x/week Never

Exercise, Stress and Sleep – THIS INFORMATION IS REQUIRED – FILL OUT COMPLETELY

Do you engage in regular physical activity? Yes No

If yes, how frequently? Everyday 4-6x/week 2-3x/week 1x/week or less

How long does the average session last? 15-20 minutes 20-30 minutes 30-45 minutes 45+ minutes

What type of activity do you engage in? ____________________

____

If no, what interferes with your ability to establish & maintain a regular exercise routine? ____________________

____

On a scale of 1-10 how would you describe your usual level of stress?

0 1 2 3 4 5 6 7 8 9 10

None Moderate Extreme

On a scale of 1-10, how would you describe your quality of sleep?

0 1 2 3 4 5 6 7 8 9 10

None Moderate Extreme

Please read the list of problems and complaints below. On each line, fill in the number from the scale which best describes how much that problem has bothered or distressed you during the past week, including now .

Not at all	Slightly	Moderately	Quite a bit	Extremely
0	1	2	3	4

______ 1. Nervousness or shakiness inside.

______ 2. Unwanted thoughts, words or ideas that won't leave your thoughts

______ 3. The idea that someone else can control your thoughts

______ 4. Feeling others are to blame for most of your troubles

______ 5. Trouble remembering things

______ 6. Feeling easily annoyed or irritated

______ 7. Feeling afraid in open space or on the street

______ 8. Thoughts of ending your life

______ 9. Hearing voices that other people do not hear

______ 10. Feeling that most people cannot be trusted

______ 11. Crying easily

______ 12. Feeling of being trapped or caught

______ 13. Suddenly scared for no reason

______ 14. Temper outbursts that you could not control

______ 15. Feeling afraid to go out of your house alone

______ 16. Feeling blue

______ 17. Worrying too much about things

______ 18. Feeling fearful

______ 19. Other people being aware of your private thoughts

______ 20. Feeling afraid to travel on buses, subways or trains

______ 21. Having to avoid certain things, places or activities because they frighten you

______ 22. Your mind going blank

______ 23. Feeling hopeless about the future

______ 24. Trouble connecting

______ 25. Having thoughts that are not your own

______ 26. Having urges to beat, injure, or harm someone

______ 27. Having urges to break or smash things

______ 28. Having ideas or beliefs that others do not share

______ 29. Spells of terror or panic

______ 30. Getting into frequent arguments

______ 31. Feeling nervous when you are left alone

______ 32. Feeling so restless that you could not sit still

______ 33. Feelings of worthlessness

______ 34. Feeling that familiar things are strange or unreal

______ 35. Shouting or throwing things

______ 36. The idea that you should be punished for your sins

______ 37. The idea that something is wrong with your mind

Religious Preference: ____

In addition to my primary care physician, The Weight and Wellness Center has my permission to release information to:

Name____

Street Address____

City, State, Zip____

Signature date

Patient Name ______________________

MR # and Date of Birth ______________________

Primary Care Physician ______________________

Always carry a list of current medications with you in case of an emergency. Provide an updated list to your Primary Care Physician or any provider who prescribes you medication. Remember to keep your list updated. Include all over the counter medications such as vitamins and herbals. Discard all old medication lists.

ALLERGIES

Drugs, Food	Reaction
Allergies to: Latex ☐ Yes ☐ No Contrast dye ☐ Yes ☐ No	

Check if appropriate: ☐ **Pregnant** ☐ **Breastfeeding**

Immunization History	Month / Year		
Tetanus	/	/	/
Pneumococcal	/	/	/
Flu	/	/	/
	/	/	/

Vitamins, herbs & non-prescription drugs		
Name	**Dose**	**Times/Day**

Medication	Dose	How Taken (by mouth, topical, injection, rectally)	When Taken (time of day)

Medication	Dose	How Taken (by mouth, topical, injection, rectally)	When Taken (time of day)

Contacts	Name/Location	Phone No.
Emergency Contact		
Pharmacy		

OFFICE USE: Cross out discontinued meds						
Date Reviewed						
Initials						

www.mysignaturecare.org/weightloss
Tel: 508-894-0766
Fax: 508-565-0097

INSURANCE QUESTIONS

Below are some questions to guide you through a discussion with your insurance company. Verifying your insurance coverage and understanding the benefits specific to your own policy is an extremely important step to starting your weight loss surgery journey. It is highly recommended that you call PRIOR to your first appointment.

1. Does my insurance policy cover Weight Loss Surgery?

____

____

* Please know that out of state policies may have different coverage. (i.e. BCBS of Massachusetts is NOT the same as BCBS of New Jersey)

2. Does my policy have any restrictions for Weight Loss Surgery?

____

____

3. Which surgeries are covered: Laparoscopic Gastric Bypass (CPT Code: 43644), and/or Laparoscopic Gastric Sleeve (CPT Code: 43775)?

____

____

____

4. What are the requirements for insurance approval of Weight Loss Surgery?

____

____

____

____

____

* Some insurance companies (i.e. Mass Health, Aetna, and Cigna) require documentation of non-surgical, physician monitored weight loss attempts for 3-6 consecutive months.
* Please know out of state policies may have different requirements (i.e. BCBS of Massachusetts is NOT the same as BCBS of Georgia)

5. What percent of the total bill will I be responsible for and is there a deductible that I will need to pay?

____

____

____

6. Does my insurance cover Medical Nutrition Therapy for treatment of morbid obesity (ICD10 code: E66.01)? If so, how many visits are covered per year? How much is my co-pay?

____

____

____

*Please be advised, some insurance companies will only cover Medical Nutrition Therapy for a diagnosis of diabetes, NOT for morbid obesity.
*Some insurance companies will only cover a limited number of visits with a Nutritionist.

7. Does my insurance cover outpatient behavioral health visits? If so, how many are covered per year? How much is my co-pay amount?

____

____

____

8. Do I need referrals?

____

____

* If your insurance requires referrals to see a specialist and your PCP is NOT part of Signature Medical Group, you will need to call your doctor's office and request the referral as soon as you have an appointment booked. **You will not be able to be seen without the referral in place**.
* If your insurance requires referrals to see a specialist and you have a Signature Medical Group PCP we will handle everything internally for you.

Answers to questions your insurance company may ask you:

Surgeon: Deborah Abeles, MD, FACS, FASMBS
Surgeon NPI: 1063528925

Nutritionist: Jordan Boucher, RDN, LDN
Nutritionist NPI: 1215310669

Nutritionist: Lauren Ahola, MS, RDN
Nutritionist NPI: 1295191377

Behavioral Health Specialist: Dean Howell, LISCW
Behavioral Health Specialist NPI: 1407353154

Behavioral Health for Tufts Health Plan or Cigna: David Leiman, MD

NPI: 1790713014

Addresses:	Weight & Wellness Center 110 Liberty Street Brockton, MA 02301
	Brockton Hospital 680 Centre Street Brockton, MA 02302
Phone:	508-894-0766
Fax:	508-565-0097
Your diagnosis code:	E66.01
Procedure codes:	Laparoscopic Gastric Bypass = 43644 Laparoscopic Sleeve = 43775

Keep track of who you speak with and any reference numbers:

Spoke to: ____________________ Ref. #: ___________________ Date: ______________

Spoke to: ____________________ Ref. #: ___________________ Date: ______________

Spoke to: ____________________ Ref. #: ___________________ Date: ______________

I found out my insurance plan does cover bariatric surgery. Now what should I do?

- Some insurance companies require that you are referred to a bariatric surgeon by your PCP; others do not. Either way, he or she will need to work closely with Dr. Abeles throughout the whole process and for your follow-up care. So, if you're due for a checkup, now's the time to make an appointment and let your PCP know what your plans are. Also, the Weight & Wellness Center does require documented medical clearance from your PCP within 30 days prior to your surgery.

- Make sure your medical records are in order, including any history of dieting or other weight loss efforts. These records will be used to write a letter of medical necessity which is required for insurance pre-authorization. It's helpful if PCP has documented your attempts to lose weight in his or her office records.

- If your PCP is <u>not</u> part of Signature Medical Group, you must request to have your most recent office notes faxed to us: **508-565-0097**

- If your PCP is <u>not</u> part of Signature Medical Group and your insurance requires a referral to see a specialist, make sure you request the referral soon enough to have it processed and in place prior to your appointment. If your referral is not in place on the day of your appointment, you will need to reschedule. You should request referrals for 12 visits with Dr. Abeles (NPI 1063528925) and 12 visits with Rachel Wyman, RD, LDN (NPI 1841595808) as soon as you are booked for your Steps session.

- If you have any specialists (i.e. cardiology, endocrinology, gastrointestinal, etc.) that are not part of Signature Medical Group, or if you've had any surgery outside of Brockton Hospital, you will need to request to have your records, recent lab or test results, and operative reports sent to us for Dr. Abeles to review. Not doing so can delay or prevent your being cleared for bariatric surgery. Records can be faxed to us at: **508-565-0097**